A STUDY TO ASSESS THE EFFECTIVENESS OF PSYCHOEDUCATION ON KNOWLEDGE AND ATTITUDE REGARDING ECT AMONG THE CARE GIVERS OF MENTALLY ILL AT SELECTED HOSPITALS,TRICHY.

BY

REG. NO: 301332101

A DISSERTATION SUBMITTED TO THE TAMILNADU DR.M.G.R.MEDICAL UNIVERSITY, CHENNAI –32 IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN NURSING

OCTOBER - 2015

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OCTOBER – 2014

DECLARATION

I hereby declare that this dissertation entitled "**A study to assess the effectiveness of Psycho education on knowledge and attitude among the care givers of mentally ill at selected hospitals, Trichy."** outcome of the original research work undertaken and carried out by me, under the guidance of research guide **Prof. Mrs.VANITHA INNOCENTRANI, M.Sc(N), Ph.D.,** Professor cum Principal, and **Mrs. SARANYA, M.Sc(N),** HOD of Mental Health Nursing Department, Our Lady of Health College Of Nursing, Thanjavur.

I hereby declare that the material of this has not found in any way, the basis for the award of any degree / diploma in this university or any other university.

301332101

CERTIFICATE

CERTIFIED THAT THIS IS THE BONAFIDE WORK OF

301332101

AT OUR LADY OF HEALTH COLLEGE OF NURSING,

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SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN NURSING FROM THE TAMILNADU DR.M.G.R MEDICAL UNIVERSITY, CHENNAI.

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LIST OF ABBREVIATIONS

SHORT FORMS	ABBREVIATIONS
AJP	American journal of psychiatry
APA	American psychiatric association
ECT	Electroconvulsive therapy
FIG	Figure
H1	Research Hypothesis
M.Sc (N)	Master of Science in Nursing
No	Number
N	Number of samples
F	Frequency
%	Percentage
SD	Standard deviation
χ^2	Chi-square

ABSTRACT

ECT is an effective treatment for psychiatric disorders. Some patients may require treatment with continuation or maintenance ECT because other treatment have not been effective in preventing illness relapse. The study focuses on effectiveness of psycho education on knowledge and attitude regarding ECT among the care givers of mentally ill at selected hospitals, Trichy. The statistical analysis revealed that the knowledge and attitude of the experimental group was calculated by the paired 't'test for knowledge ('t'=14.3428) and for attitude ('t'=9.4977). Where as in control group the paired 't' test for knowledge was ('t'=2.0088) and for attitude ('t'=1.7873). This proves that there was a significant difference in pre test and post test level of knowledge and attitude of the experimental group at 0.05 level of significance. And unpaired 't' test for pre knowledge was ('t'=0.1613) and for pre attitude ('t'=0.0717).Where as in post unpaired 't' test for knowledge was('t'=11.7508) and for attitude ('t'=8.7789). Where as in correlation between the post test scores of knowledge and attitude of the experimental and control group states the 'r' value (r=0.8095) it reveals that there is a positive and highly significant correlation between the knowledge and attitude regarding ECT in control group the 'r' value (r=0.3145) it reveals that there is a positive and moderate significant correlation between the knowledge and attitude regarding ECT. It indicates the given Psycho education was effective.

CHAPTER- I

INTRODUCTION

CHAPTER-I

INTRODUCTION

"Always bear in mind that your own resolution to succeed is more important than any other one thing."

- Abraham Lincoln.

BACK GROUND OF THE STUDY

Knowledge explosion and the impact of science and technology is being felt in all walks of life. Its impact is greatly felt in medical science where in more complicated instruments have been designed and used in various types of diseases. One such design used in treating mental illness is ECT .

Electro convulsive therapy is one of the most controversial treatment used in modern psychiatry. ECT has very bad press. In the movie "one flew over the cuckoo's nest", its depicted as a physically and emotionally brutal procedure imposed on unwilling clients in order to calm them. Today, ECT remains one of the most controversial treatments for psychological disorders and continues to be the subject of impassioned debate among various functions of society, within both the professional and lay communities.

London medical journal in 1785 was first documented that the use of ECT. Methods of inducing seizure or convulsions as a way of treating psychiatric conditions early as 16th century. At that time the conditions were largely untreatable due to medications not being as developed or advanced as they are today .

In 1937 the first international meeting on ECT took place in switzerland, under the organization of swiss psychiatrist Muller. The proceedings from this meeting were published in the **American Journal Of Psychiatry** and with in 3 years, ECT using Cardiazol (metrozol) was being used across the world.

Next neuro psychiatrist **Ugo Cereletti** and his colleague **Lucio Bini** who had been conducted animal experiments by using electric shocks, they introduced the ideas of replacing Cardiazol with electric shock treatment as the method for inducing a convulsion.

In 1940's Cereletti and Bini were nominated for a Nobel Prize for the work of identified the use of ECT, then it had become wide spread in England and the US. The electric shock method was cheaper and more convenient than the Metrozol method but it was also less predictable and controllable. In 1950's the popularity of the technique also spread throughout the world.

Then the use of ECT gradually declined over the years, mainly due to poor public perception of the technique, partly as a result of its portrayal in film and media.

In 1978, the first task force report from the **APA** was released introducing new standards for consent and recommending use of unilateral electrode placement. In 1980's the therapy became more popular again when the benefits to the patients with severe refractory depression became obvious. In 1985 , the **NIMH** consensus conference supported the use of ECT in certain clinical circumstances .

In 1990, the **APA** released 2nd report further detailing guidance on the delivery of ECT as well as a training and education. In 2001 latest task force report from the **APA**, emphasized the importance of the patient's informed consent as well as the extended role ECT plays in medicine today.

World wide, it has been estimated that about 1 million patients receive ECT annually. ECT appears to have become a widely available treatment for mental disorders on all continents. A survey of the practice of ECT in 188 teaching institutions and psychiatric hospitals in India, showed that more than 70% of ECT administrations were performed in psychiatric hospitals and approximately half of ECT use was on unmodified ECT .

In 2009 ECT spread rapidly from Europe to other continents and to the US, due to the 2nd world war's displacement of psychiatrists shorter. In the beginning, ECT was administered without anesthesia and later , under anesthesia together with muscle relaxant Succinylcholine medication, in order to reduce side effects from the convulsions such as bone fractures, teeth, tendon and muscular damage.

We know much about scientific nature of ECT. But care givers remain for more time with patients. So it becomes necessary to search that, whether care givers have sufficient knowledge about ECT, which they are applying on their loved one. At the same time one will be interested to search their attitude towards ECT.

NEED FOR THE STUDY

Win as if you were used to it, lose as if you enjoyed it for a change.

-Golnik Eric

Man is in search of knowledge since time immemorial. Knowledge is all that is known or information. While gathering knowledge about particular thing, he develops attitude towards it simultaneously. Some scholars and researchers attempted to explore knowledge and attitude towards ECT.

ECT is effective in the treatment of psychiatric disorders. Some patients may require treatment with continuation or maintenance of ECT because other treatment have not been effective in preventing the illness or relapse. Continuation or maintenance of ECT consists of further treatments given after the end of the acute treatment course, to prevent relapse. It typically ranges from an ECT treatment given every week to every few weeks.

There have been substantial development which have improved the practice of ECT in recent years . There are several valid treatment approaches

and there is no single “protocol” for administering ECT. The treatment approach needs to be individualized to the patient, his or her disorder and response to ECT. The practice of ECT in supported by active research aimed at improving efficacy and minimizing side effects.

Among other reasons, care givers may refuse ECT when indicated due to myth and little or lack of knowledge about the procedure. The knowledge and attitude towards ECT among the care givers may reflect on patients and influence the treatment of choice.

Although ECT is an effective, safe and widely practiced treatment , it has also been one of the most controversial and misunderstood procedure. Unfortunately , in the ongoing debate about the merits and demerits of the treatment, the opinions of their relatives have rarely been sought.

Iodice AJ. et. al.(2003) the department of psychiatry and behavioral medicine, Wake Forest university school of medicine, USA. This study examined the stability of patient’s attitudes significantly different, which suggests that attitudes toward ECT are stable during this time.

Chavan BS. et. al. (2006) stated that, people had lack of knowledge and inappropriate attitude towards ECT. As care givers stay continuously with the patient and various render care, they may posses some knowledge and have some kind of attitude towards ECT.

Rajagopal R et. al.(2013) stated that most patients and their relatives, were satisfied with ECT, but these were several areas of including the fear of ECT, lack of information, and the possibility of enduring cognitive problems. This study also underline the need for a well validated and reliable method of assessing satisfaction with ECT.

Dan A, et. al. Indian Journal of Psychology medicine(2014) explained that the majority of the patients and relatives were unaware of the basic facts about ECT they did not have any major impact in knowledge and

attitude in both patients and relative groups. Since patients and relatives have poor knowledge and negative attitude toward ECT, medical professionals should impart proper information about ECT to patients and relatives to the acceptability of this treatment.

While searching scholarly literature it was found that, though there are various researches on care givers knowledge and attitude towards ECT, but very few studies are conducted in Indian context. So it becomes a strong evidence for the recommendation need for further study. Hence researcher strongly feels that, there is a need to conduct a study to assess the care givers knowledge and attitude towards ECT.

STATEMENT OF THE PROBLEM

A study to assess the effectiveness of psycho education on knowledge and attitude regarding ECT among the care givers of mentally ill at selected hospitals, Trichy.

OBEJECTIVES

- To assess the knowledge and attitude regarding ECT before and after providing the psycho education among the care givers of mentally ill.
- To evaluate the effectiveness of psycho education regarding ECT among the care givers of mentally ill in experimental group.
- To compare the levels of knowledge and attitude between the experimental and control group regarding ECT.
- .To correlate the post test scores of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

- To determine association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group and their selected demographic variables.

HYPOTHESES

All the hypotheses were tested at 0.05 level of significance.

- H1: There will be a significant difference between the pre and post test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in experimental and control group.
- H2-There will be a significant difference between the experimental and control group knowledge and attitude regarding ECT.
- H3: There will be a significant relationship between the post test scores of knowledge and attitude regarding ECT among the care givers of mentally ill in experimental and control group.
- H4: There will be a significant association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group and their selected demographic variables.

OPERATIONAL DEFINITIONS

Effectiveness

In this study, it refers to the influence of psycho education regarding ECT among the care givers of mentally ill as expressed by

improvement in knowledge and attitude.

Psycho education

It refers to the organized teaching strategies which includes the meaning of ECT, action, indications, side effects of ECT, pre and post of ECT care and home care all the contents should be educated to givers of mentally ill.

Knowledge

It refers to the response given by the care givers of mentally ill regarding ECT which will be measured by the using semi structured interview questionnaire.

Attitude

In this study it refers to the self belief or perception of women about weight reduction measures which is measured with the help of Likert scale.

ECT

It refers to the passage of an electric current through electrodes which will be placed in the frontal lobe which affects the catecholamine pathways between the diencephalon and limbic system in the brain.

Mentally Ill

It refers to the patients those who are diagnosed as mania, bipolar affective disorder, depression and anxiety disorder according to ICD-10 criteria and who are admitted in the psychiatric hospital.

Care Givers of Mentally Ill

In this study, it refers to any one of the patient close relatives (parents, spouse, siblings) who is an adult, staying with them.

ASSUMPTION

- The care givers of mentally ill are not aware about ECT and after care of patient.
- The psycho education on ECT may improve the knowledge and attitude to the care givers after ECT.

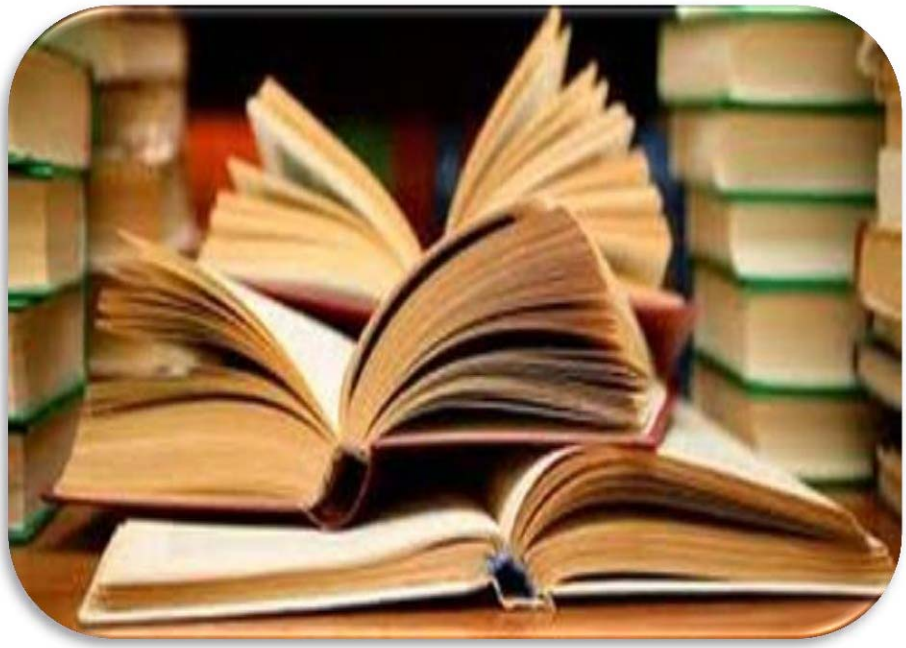
DELIMITATION

- The study will be limited to the care givers of mentally ill who are available at the time of data collection.
- The data collection period will be limited to 6 weeks.

PROJECTED OUTCOME

- The psycho education on the ECT may improve the knowledge and attitude regarding ECT among the care givers of mentally ill.

CHAPTER- II



REVIEW OF LITERATURE

CHAPTER II

REVIEW OF LITERATURE

Review of literature is broad, comprehensive, in depth, systematic and critically review of scholarly publications, unpublished scholarly print materials, audiovisual materials and personal communications. Review of literature is the key step in nursing process. It refers to an systematic examinations of publications relevant to the research project.

EMPRICAL LITERATURE

AMITAVA DAN A, et al. Indian Journal of psychological medicine 2014 We conducted knowledge and attitude regarding ECT were assessed using the Bengali version of the ECT knowledge and attitude questionnaires, between 100 clinically stable patients with mental illness and their health relatives. No significant difference was observed in knowledge and attitude patients who had obtained their facts from doctors (n=23) and from other source (n=77), relatives had obtained their information from doctors (n=27) were better informed than those who had obtained so from other sources (n=73).

MONDAY IGWE N, et al. Open journal of nursing 2014 We conducted electroconvulsive therapy in the eyes of undergraduate nursing students. The total mean score of the students was 7.53+2.65. 58 (71.6%) students observed on ECT procedure and followed up the observed the procedure scored 6.98+1.92 on the QUAKE (t= -0.36,p= 0.72). 31 (38.3%) students who would accept the procedure if indicated scored 7.14+2.21 while 50 (61.75) of them who would not allow ECT carried out on them scored 6.88+1.96 (t= 0.56, p= 0.58).Therefore, there is a need to improve undergraduate nursing education on ECT.

AKI OE, et al . Journal of ECT 2013 Conducted knowledge and attitude toward ECT among medical students psychology students and the general public. A Likert type questionnaire was administered, it included questions about the general principles and indications for ECT, source of knowledge and attitude toward ECT. The medical students were the most knowledgeable about ECT, as expected. The medical students also had a more positive attitude toward ECT than the other two groups. More psychology students had negative attitudes on some aspects than general public sample, despite being more knowledgeable.

ALAA EL DIN M. DARWEESH, et al 2013 Conducted assess the knowledge and attitude about ECT among the care givers of patient with psychiatric disorders. The study sample included 450 care givers of patient; 286 were men and 264 were women. In all 50.4% of the participants had not received information about ECT. The main significant factor affecting this knowledge and attitude was the precious experience of their patients with ECT.

JAMES BO, et al. Journal of ECT. 2013 Conducted cross sectional study of modified ECT in Nigeria current status and psychiatric attitudes of psychiatrist and trainees. Most psychiatric facilities still make use of the unmodified type of ECT. Although half of the respondents considered their knowledge of ECT inadequate, most 92.2% considered ECT relevant in contemporary times and preferred that the modified format be used (73.7%).

PATRY S, et al. Journal of ECT. 2013 Conducted present survey data on the teaching of ECT in health care centers across Canada. 1273 centers identified, 175 were found to practice ECT. 60% of respondents had no ECT teaching program for psychiatric residents. Pedagogical methods varied, ranging from direct observation of ECT treatments to directed readings. Few centers required a minimum number of supervised treatments. No resistant- administered ECT is performed without direct supervision.

RABHERU K, et al. Journal of ECT 2013 Conducted study comparison of traditional didactic seminar to fidelity simulation for teaching ECT technique to psychiatric trainees. 19 psychiatric residents participated in this randomized controlled trail to compare traditional training (n=9) versus training using an HPs (n=10). Two blinded rate's assessed performance using a newly developed check list and global rating scale for this task. All 10 of the HPs group received a "pass" rating following training, where as only one of the 9 control group received a "pass" rating. There were no significant group difference in post test confidence(p=0.21).

RAJAGOPAL R, et al. Journal of ECT. 2013 Conducted satisfaction with ECT among patients and their relatives of the 110 patients received ECT over 2 years, 50 were eventually recruited. In this study using patient satisfaction survey. Slightly more than half of the patients of this study appeared to be satisfied with ECT., as reflected by overall levels of satisfaction 54%,satisfaction with results of ECT 54%, satisfaction with the staff administering ECT58%, and satisfaction with the positive effects of ECT on their symptoms 63%.

DR.ABDULQADER HUSSEIN HAMAD, et al. Journal of ECT. 2012. Conducted a quantitative design, descriptive study with A non-probability purposive sample, 100 patient's family attending the psychiatry services in a major hospital in Sulemani. It was carried out in Sulemani hospital for the period from November 2011 to April 2012. 9% of the respondents in patient's family consider that ECT is a treatment, and of them considered ECT is investigation. 6% answered the ECT has not contra indication and 50% answered ECT has not complication.

GOLENKOV A, et al. Journal of social psychiatry 2012. Conducted study offer public attitude towards ECT in the Chuvash republic. A randomly selected cohort of 5373 people was contacted by telephone. The respondents were

asked 3 closed and 3 open questions. The response rate was 74.7%, only 35.2% of those interviewed said they knew anything about ECT. Health professionals and younger respondents were better informed. The 2 main sources of information about ECT were foreign films and mass media. The majority 63.3% of the respondents had negative opinions and emotions about ECT.

RAJAGOPAL R, et al. Journal of ECT. 2012 Conducted knowledge experience and attitudes concerning ECT among the patients and their relatives. Of the 153 recipients of ECT, 77 patients and relatives were eventually assessed using questionnaires designed to evaluate their awareness and views about ECT. Though most did not find the experience of ECT upsetting, sizeable proportions expressed dissatisfaction with aspects such as informed consent, fear of treatment and memory impairment. Although patients were mostly positive about ECT, ambivalent attitude were also common, but clearly negative views were rare.

AKINSOLA O, et al. Journal of ECT 2011 Conducted a national postal survey of 415 trainees was conducted in September 2008 using a self- designed 15- item questions for the purpose of the study, containing no identification data and incorporating relevant questionnaires item from similar published trainees survey. Overall response rate was 61%. 91% of trainees had worked in ECT centers, of which 35% had given ECT on an occasion without direct consultative supervision. Overall, 12% of trainees had never administered or observed ECT, which includes 2 trainees on the national senior registrar scheme, and 19% of trainees had nil or minimal confidence in their ability to administer ECT.

FETTERMAN & YING, 2011 Stated informed consent and ECT. The nurse may be responsible for ensuring that informed consent has been obtained from the client. If the depression in severe and the client clearly unable to consent to the procedure, permission obtained from family members or another legally responsible individual. Consent is secured only after the client or responsible

individual acknowledges understanding of the procedure including possible side effects and potential risk involved. Client and family must also understand that ECT is voluntary, and that consent may be withdrawn at any time.

FISHER P, et al. Journal of mental health 2011. Conducted patients perceptions of the process of consenting to ECT. 12 participants were interviewed about their experiences of consenting ECT. Interviews were subjected to a thematic analysis. Participants perception of consenting to ECT were complex and interpersonal factors were found to be important. Many participants felt that they had consented without adequate information from medical sources and that they had little choice to agree.

LAMONT S, et al. International Journal of Mental health Nurse 2011 Conducted evaluation of an ECT service in general hospital. A significant finding of the audit was that the majority of patients were treated under the New South Wales mental health act, and voluntary patients were more likely to have a non-mood disorder diagnosis. This study shown that auditing of ECT practices and services by mental health nurses in essential for quality improvement process.

M KHEIRI, et al. Procedia- social and behavioural sciences 2011 Conducted the study of education effect on knowledge of, and attitude towards ECT among Iranian nurses and patients relatives in a psychiatric hospital, 2009-2010. In this research pre and post test self administered questionnaire were completed by 46 relatives and 46 nurses before and after education about ECT. Nurses in this research received a mean score of X=34.97 knowledge before education and X=39.78 after education ($t=2.02, p<0.05$), and a mean score of X=33.41 attitude before education and, X=42.82 after education ($t=-14.25, p,0.001$).

SCHEWEDER LJ, et al. Journal of ECT. 2011 Conducted questionnaire study about the practice of ECT. 42 item questions on the practice of ECT was sent to all the 125 Norwegian psychiatric hospitals, district psychiatric centers, and child and adolescent psychiatric units in 2004. Trainee psychiatrist mostly administered ECT, with or without supervision, but underwent a training program before administering ECT. Written informed consent was used in 50% of institutions providing ECT. Right unilateral electrode placement preferred but with variations in dosage strategies.

SIENAERT P. CAN Journal of Psychiatry 2011 Conducted what we have learned about ECT and its relevance for the practicing psychiatrist. In this narrative review, the current knowledge base on the efficacy and the practice of ECT is reviewed, and its relevance for the practicing psychiatrist is appreciated. Research focusing on further minimizing memory problems, while maintaining a superior efficacy is ongoing.

THABET JB, et al. Encephale 2011 Conducted reticence towards ECT a study of 120 care givers in a teaching hospital in Tunisia. The surveyed people answered an auto questions essentially 16 items;11 had binary answers related to theoretical knowledge about ECT, and 5 others expressed the perception and attitudes concerning this therapy. Overall result concerning the item exploring theoretical knowledge, 67.5% of people were not able to answer, in conformity with the consensual scientific data, a minimum of 75% questions.

CHAKRABARTI S, et al. World Journal of bio-psychiatry 2010 Conducted a review of knowledge, experience and attitudes of the patients concerning the treatment. 75 reports were for suitable. The evidence from these studies suggested that patients undergoing ECT were usually poorly informed about it. This was attributable to factors such as unsatisfactory pre treatment

explanations or post ECT memory impairment. About one third undergoing ECT reported feeling coerced to have the treatment.

GOLENKOV A, et al. European psychiatry 2010 Conducted the practice of ECT and the attitudes of psychiatrists towards ECT in the Chuvash republic are described. A significant proportion of Chuvash psychiatrists had a patchy knowledge about ECT and held negative attitudes towards the treatment. Enhancing the knowledge about ECT and changing negative attitudes will require persistent educational efforts.

JAMES BO, et al. Journal of Psychiatric mental health nurse 2010 Conducted cross sectional survey of 135 student nurses and staff mental health nurses showed that knowledge and attitude scores were more positive among staff mental health nurses compared with student mental health nurses. Additional years of experiences correlated with better knowledge and positive attitudes among staff mental health nurses. Overall, the majority of the respondents felt that ECT was beneficial to patients and required guidelines for its practice in this country.

JAMES BO, et al. African health Science. 2009 Conducted a 14 –item self administered questionnaire was administered to 5th year medical students at the commencement of their psychiatric rotation, then 4 weeks later to assess the knowledge and attitude towards unmodified ECT. There were significant improvements in knowledge and change in attitude measures to myth about ECT following our intervention.

LEUNG CM, et al. Journal of ECT. 2009 Conducted modified and unmodified ECT : a comparison of attitudes between psychiatrist .105 psychiatrists of a university-affiliated psychiatric hospital in Beijing and all psychiatrists currently practicing in Hong Kong were invited to complete a questionnaire exploring their attitudes toward modified and unmodified ECT. The

Beijing respondents had significantly more experience with unmodified ECT than their Hong Kong counter parts. Although 56% of the Beijing respondents preferred modified to unmodified treatment, 81% of them regarded unmodified ECT as safe and associated with minimal morbidity and mortality.

SHAH N, et al. Journal of ECT.2009 Conducted third year medical students understanding, knowledge, and attitudes toward the use of ECT. All third year medical students were asked to complete a survey regarding their opinions about ECT before and after their third year psychiatry rotation, and they were asked whether they received the required didactic ECT training alone or also received adjunctive observation training. The opinions of students both groups improved significantly from pre-rotation to post-rotation.

MCFARQUHAR TF, et al. Journal of ECT. 2008.Conducted knowledge and attitude regarding ECT among medical students and the general public. Participants were opportunistically recruited for a Likert scale questionnaire developed for this study. The lay sample was significantly less knowledgeable and had less positive attitudes and greater fear of ECT than the medical students. The aspects of ECT that medical students were least knowledgeable about were the potential risks and the side effects involved.

OLDWENING K, et al. Journal of ECT. 2007 Conducted effects of an education training program on attitudes to ECT. The ECT education training program consisted of a brief lecture , viewing of an videotape , familiarization with the ECT equipment , and observation ECT treatment. participants completed a short questionnaire pre training and post training program. For the entire sample, only 8.5% reported that they were well informed about ECT before the training session.

VIRIT O, et al. Journal of ECT. 2007. Conducted patient's and their relative's attitudes toward ECT in bipolar disorder. In this study, the perspectives of 70 bipolar patients and their 70 relatives were examined before ECT. The study showed that the majority of the patients and relatives believed they had not received adequate information about ECT, but they were satisfied with the treatment, found it beneficial, and maintained a positive attitude toward its use.

WOOD JH, et al. J ECT. 2007. Conducted questionnaire study including 211 registered nurses working in London Mental Health trust. There was a highly significant correlation between the knowledge of and more positive attitudes to ECT. The more years in mental health, higher grade, and the greater number of patients undergoing ECT they had contact with correlated with more knowledge. Registered nurses had more positive attitudes than student nurses.

PART: II CONCEPTUAL FRAME WORK

KING'S GOAL ATTAINMENT THEORY

A unique knowledge base and the means and to communicate it are requisite for a profession. Nursing continuous to be deeply involves in developing its own unique knowledge base and in educating care givers.

The study is based on Imogene king's goal attainment theory(1997) which would be relevant for Psycho education on ECT. Imogene king's system is an open system. In this system human are in constant contact interaction with their environment.

The main concepts in Imogene king's open system are perception a process of organizing, interpreting and transforming information from sense data and memory that drives meaning to one's experience to represent one's image of reality and influence one's behavior.

Perception

In this study the researcher perceives that most of the care givers of mentally ill had inadequate knowledge and attitude regarding ECT.

Judgment

In this study the researcher judges that the Psycho education is effective in improving the knowledge and attitude regarding the ECT. It provides confidence to handle the patient during the ECT treatment.

Action

In this study the researcher prepare the psycho education is effective in improving the knowledge and attitude on ECT among care givers of mentally ill.

Mutual goal setting

In this study it is an activity that includes the care givers when appropriate in prioritizing the and in developing the plan of action to achieve those goals. Here in this study both the researcher and student accept to undergone with research study.

Reaction

The researcher plan together and moves towards goal attainment. Here the researcher plan to teach the ECT procedure after conducting the pre test to the experimental group.

Interaction

The act of two or more persons in mutual presence and sequence of verbal and non verbal behaviors that are directed towards goal.

In this study interaction includes pre test (for assessing the knowledge and attitude) then administration of psycho education and post test to the samples of experimental group and no intervention to the samples of the control group.

Transaction

In this study the transaction includes post test on the assessment of knowledge and attitude on ECT among the care givers of mentally ill.

In this study the researcher and the subject came together for an interaction, a different set of perception to exchange. The researcher perceives the subject need to teaching ECT procedure to the care givers to handle the patient during the ECT treatment.

The researcher communicates the subjects by implementing the psycho education regarding ECT transaction between the subjects takes place. The goal is

said to be achieved is an increased level of knowledge and attitude in experiment group when compared to control group.

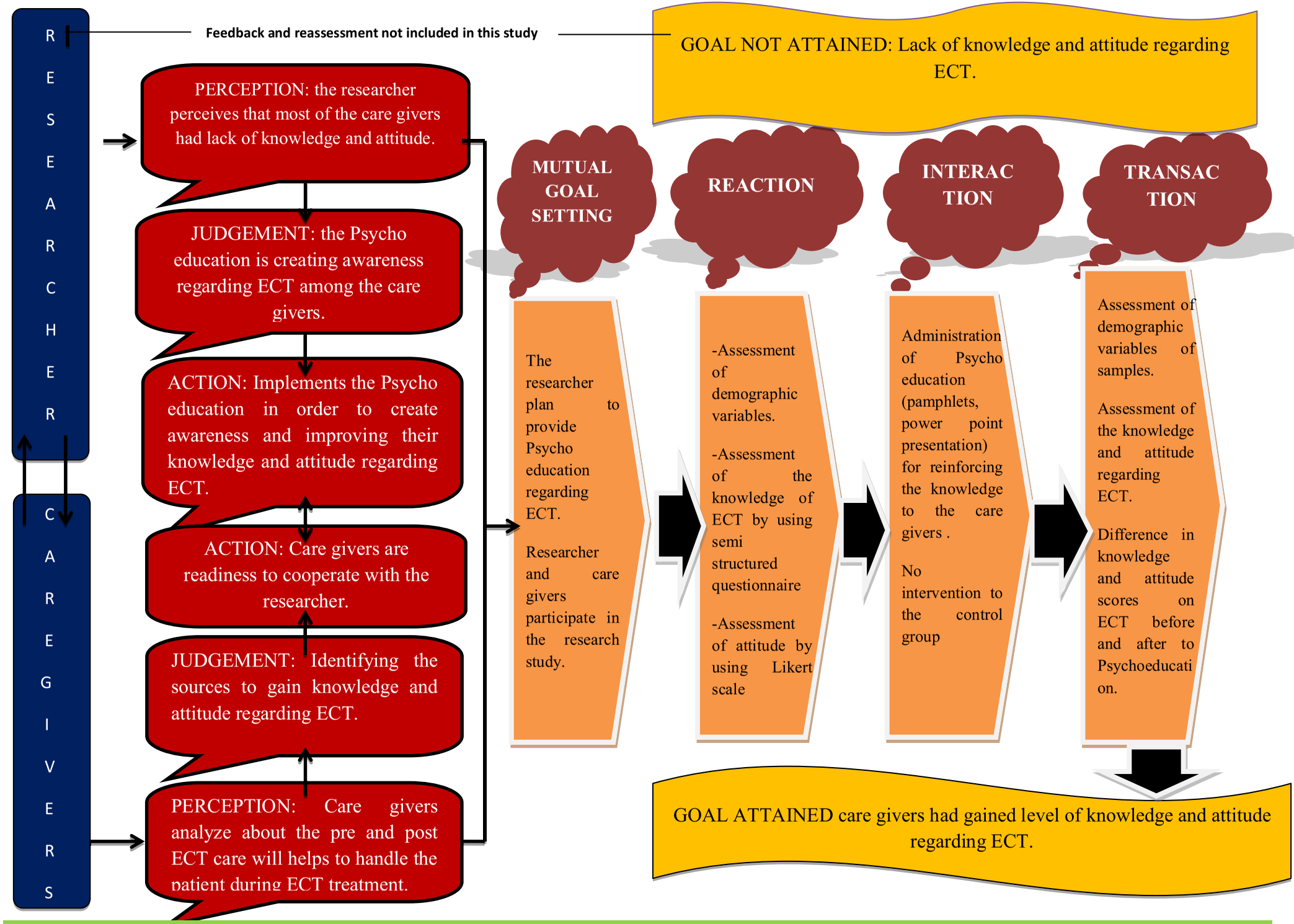


Fig-2.1:Conceptual Framework based on King's Goal Attainment Theory (1997) to evaluate the effectiveness of Psycho education regarding ECT among the care givers.

CHAPTER - III

RESEARCH METHODOLOGY

CHAPTER-III

RESEARCH METHODOLOGY

Research methodology is a way to systematically solve the research problem. In this chapter the investigator discusses the research approach, research design, variables, setting, population, sample size, sampling technique, criteria for data collection, description of the tool, plan for data analysis and protection of rights.

RESEARCH APPROACH:

An evaluative approach was used in this study.

RESEARCH DESIGN:

Quasi experimental research design (non-equivalent control group pre test – post test design) was chosen for this study.

EO1	X	O2
CO1	_	O2

E- Experimental group

O1- Pre test

X- Intervention

O2- Post test

C- Control group

VARIABLES:

Independent variable: Psycho education regarding ECT.

Dependent variables: Knowledge and attitude regarding ECT.

Demographic variables: It includes age of the care givers, sex, relationship to patient, education, occupation, areas of residence, duration of stay with the patient and previous source of information.

SETTING:

The study was conducted at care givers of mentally ill at Athma and Sowmanasya psychiatric hospitals, Trichy. Athma hospital was experimental group, sowmanasya hospital was control group. Both hospitals were administering ECT for daily and patients strength was depending upon the admission of the patient.

POPULATION:

The population comprised the care givers of mentally ill at selected psychiatric hospitals, trichy.

SAMPLE:

The sample comprised of care givers of mentally ill (who are receiving ECT for mental illness) at selected psychiatric hospitals, Trichy.

SAMPLE SIZE:

The sample size comprised of 80 care givers of mentally ill.

Experimental group:40 care givers

Control group:40 care givers

SAMPLING TECHNIQUE:

Non-probability convenient sampling technique was used for this study.

CRITERIA FOR SAMPLE SELECTION:

INCLUSION CRITERIA:

- The care givers of mentally ill who are available during the period of data collection
- Care givers of mentally ill patients (who are receiving ECT) for the first time.

EXCLUSION CRITERIA:

- Care givers of mentally ill patients who are receiving other therapies.
- Care givers of mentally ill patients who are contra indicated to ECT.

DEVELOPMENT AND DESCRIPTION OF THE TOOL:

The tool comprised of III parts:

Part I : Demographic variables.

Part II : Semi structured knowledge questionnaire was used to assess the level of knowledge among the care givers of mentally ill.

Part III : 5 point Likert scale was used to assess the attitude regarding ECT among the care givers of mentally ill.

REPORT OF THE PILOT STUDY:

Pilot study was conducted to test the reliability, practicability, validity, and feasibility of the tool. Pilot study was conducted for a period of 2 weeks. The investigator obtained a written permission from the head of the institutional authorities and the investigator obtained the oral permission from the participants prior to the study. Non-probability convenient sampling technique was used to select the samples. On day one pre test was conducted by using semi structured knowledge questionnaire to assess the knowledge and to assess the attitude by using 5 point Likert attitude scale. The next day psycho

education was provided to the experimental group and the effect of psycho education was assessed by post test on 7th day by using the same knowledge questionnaire and attitude scale for both experimental and control group. The result of the pilot study was analyzed by the descriptive and inferential statistics it showed the reliability coefficient so the main study was proceeded.

RELIABILITY AND VALIDITY OF THE TOOL:

The validity of the tool established with psychiatrist and nursing experts. The tool was modified according to the suggestions and recommendations of experts and the tool was finalized. The reliability of the tool was established by test- retest method (karl pearson co-efficient formula)

METHOD OF DATA COLLECTION:

Written formal permission was obtained from the head of the institutional authorities and informed consent obtained from the subject. The investigator conducted the pre test by semi structured questionnaire to assess the knowledge and 5 point Likert scale to assess the attitude. After the pre test psycho education was provided for the experimental group regarding ECT to the care givers of mentally ill . After 7 days the investigator conducted the post test to determine the knowledge and attitude of the subjects with the help of the same questionnaire.

INTERPRETATION AND SCORING PROCEDURE:

Description of the tools:

Semi structured questionnaire will have III parts,

- Part I – Demographic variables.
- Part II – It consisted of semi structured knowledge questionnaire regarding ECT among the care givers of mentally ill.
- Part III- It consisted of 5 point Likert scale to assess the attitude regarding ECT among care givers of mentally ill.

Scoring:

Part II

It consisted of 24 items related to knowledge regarding ECT. Each item carries "1"(one) mark for correct answer and "0" mark for wrong answer.

$$\frac{\text{Obtained score}}{\text{Total score}} \times 100$$

TABLE 3.1 represents the percentage for the levels of knowledge score

LEVELS OF KNOWLEDGE	SCORE	PERCENTAGE
Inadequate knowledge	0-8	0 - 33%
Moderately adequate knowledge	9-16	34 – 66%
Adequate knowledge	17-24	67 - 100%

Part III

It consisted of 15 items related to attitude regarding ECT. Each items carries "5" marks.

$$\frac{\text{Obtained score}}{\text{Total score}} \times 100$$

TABLE 3.2 represents the percentage for the levels of attitude score

LEVELS OF ATTITUDE	SCORE	PERCENTAGE
Inadequate attitude	1-25	1- 33%
Moderately adequate attitude	26-50	34 - 66%
Adequate attitude	51-75	67% - 100%

PLAN FOR DATA ANALYSIS

Collected data was tabulated and analyzed by using descriptive and inferential statistical methods.

TABLE 3.3 represents the plan for data analysis

S.NO	DATA ANALYSIS	METHODS	REMARKS
1.	Descriptive statistics	percentage, frequency distribution, mean and standard deviation	To describe the demographic variables of care givers on knowledge and attitude in both experimental and control group
		Correlation	To determine the post test scores of knowledge and attitude of care givers in both experimental and control group
2.	Inferential statistics	Paired “t” test	To assess the effectiveness of psycho education regarding ECT among the care givers of mentally ill between the experimental and control group.

		Un paired "t" test	To compare the knowledge and attitude of care givers of mentally ill between the experimental and control group.
		Chi-square test	To find out the association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill with their selected demographic variables

PROTECTION OF HUMAN SUBJECTS:

Formal permission was obtained from the hospital authorities. Research proposal was approved by the dissertation committee of Our Lady of Health College Of Nursing, prior to pilot study. After the clear explanation about the study, oral consent was obtained from each participant before started the data collection. Assurance was provided to the subject that the anonymity, confidentiality and subject privacy would be guarded.

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CHAPTER- IV

DATA ANALYSIS

CHAPTER-IV

DATA ANALYSIS

This chapter deals with the description of sample characteristics, analysis and interpretation of data collected from care givers of mentally ill regarding ECT in both experimental and control group.

ORGANIZATION OF DATA

The data has been organized and tabulated as follows.

SECTION: 1

Assessment of demographic variables of care givers of mentally ill regarding ECT in both experimental and control group.

SECTION: 2

Assessment of pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

SECTION: 3

Assessment of post test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

SECTION: 4

Comparison of pre test and post test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

SECTION: 5

Compare the significant difference in knowledge and attitude between the experimental and control group regarding ECT among the care givers of mentally ill.

SECTION: 6

Assessment of correlation between the post test scores of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

SECTION: 7

Assessment of association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group with their selected demographic variables.

PRESENTATION OF DATA

SECTION: 1

Assessment of demographic variables of care givers of mentally ill regarding ECT in both experimental and control group.

TABLE: 4.1 Frequency and percentage distribution of demographic variables of care givers of mentally ill regarding ECT in both experimental and control group.

N= 40+40=80

DEMOGRAPHIC VARIABLES	EXPERIMENTAL GROUP		CONTROL GROUP	
	Frequency (F)	Percentage (%)	Frequency (F)	Percentage (%)
Age				
≥ 25 yrs	02	05	02	05
26-35 yrs	05	12.5	05	12.5
36-45 yrs	18	45	15	37.5
46-55 yrs	14	35	18	45
≤ 56 yrs	01	2.5	-	-
Sex				
Male	10	25	10	25
Female	30	75	30	75
Relationship to patient				
Spouse	24	60	24	60
Parents	14	35	16	40
Relatives	02	05	-	-

Education				
Illiterate	13	32.5	13	32.5
Primary	03	7.5	03	7.5
Secondary	04	10	04	10
Higher secondary	09	22.5	10	25
Diploma	03	7.5	02	05
Degree	08	20	08	20
Occupation				
Employee	13	32.5	21	52.5
Un-employee	27	67.5	19	47.5
Area of residence				
Urban	09	22.5	08	20
Rural	15	37.5	18	45
Semi urban	16	40	14	35
Duration of stay with the patient				
≥ 5 yrs	24	60	25	62.5
6-10 yrs	16	40	15	37.5
≤ 11 yrs	-	-	-	-
Source of information				
Medical personnel	21	52.5	23	57.5
Media	-	-	-	-
Friends/relatives	05	12.5	03	7.5
None	14	35	14	35

TABLE 4.1 above represents the frequency and percentage distribution of demographic variables of care givers of mentally ill regarding ECT in both experimental and control group.

This table revealed that regarding the age maximum 2(5%) care givers were in the age group of <25 yrs, 5 (12.5%) care givers were in the age group of 26-35 yrs, 18 (45%) care givers were in the age group of 36-45 yrs, 14 (35%) care givers were in the age group of 46-55 yrs,1(2.5%) care giver in the age group of more than 55 yrs in experimental group. Where as in control group maximum of 2 (5%) care givers are in the age group of <25 yrs, 05 (12.5%) care givers are in the age group of 26-35 yrs, 15(37.5%) care givers were in the age group of 36-45 yrs, 18(45%) care givers were in the age group of 46-55 yrs .

Regarding the gender the maximum of 10 (25%) care givers were male and 30 (75%) female in experimental group. Where as in control group 10 (25%) male and maximum 30 (75%) care givers of female.

Regarding the relationship to patient 24 (60%) care givers are spouse, 14 (35%) care givers were parents and 2 (5%) care givers were others in experimental group. Where as in control group 24 (60) care givers were spouse, 16 (40) care givers of parents.

Regarding the education 13 (32.5%) care givers were illiterate, 3 (7.5%) care givers were primary education, 4 (10%) care givers were secondary education, 9 (22.5%) care givers were higher secondary education, 3 (7.5%) care givers were diploma education, 8 (20%) care givers were degree education in experimental group. Where as in control group13 (32.5%) care givers were illiterate, 3 (7.5%) of care givers were primary education,4 (10%) care givers were secondary education, 10(10%) care givers were higher secondary education, 02 (5%) care givers were

diploma education, 08 (20%) care givers were degree education in experimental group.

Regarding the occupation 13 (32.5%) care givers were employee, 27 (67.5%) care givers were non-employee in experimental group. Where as in control group occupation 21 (52.5%) care givers were employee, 19 (47.5%) of care givers were non-employee.

Regarding the area of residence 09 (22.5%) care givers were belongs to urban, 15 (37.5%) care givers were belongs to rural, 16(40%) care givers were belongs to semi urban in experimental group. Where as in control group 08 (20%) care givers were belongs to urban, 18 (45%) care givers were belongs to rural, 14 (35%) care givers were belongs to semi urban.

Regarding the duration of stay with the patient 24 (60%) care givers were in ≥5 yrs duration, 16 (40%) care givers were in 6-10 yrs duration in experimental group. Where as in control group 25 (62.5%) care givers were in ≤5 yrs duration, 15 (37.5%) care givers were in 6-10 yrs duration.

Regarding the source of information 21 (52.5%) care givers were gaining information from medical personnel, 05 (12.5%) care givers were gaining information from friends and relatives, 14 (35%) care givers were not gaining information from none of the above in experimental group. Where as control group 23 (57.5%) are gaining information from medical personnel, 03 (7.5%) are gaining information from friends and relatives, 14 (35%) are not gaining information from none of the above.

Figure 4.1 Represents the percentage distribution of Age the care givers in experimental and control group**.**

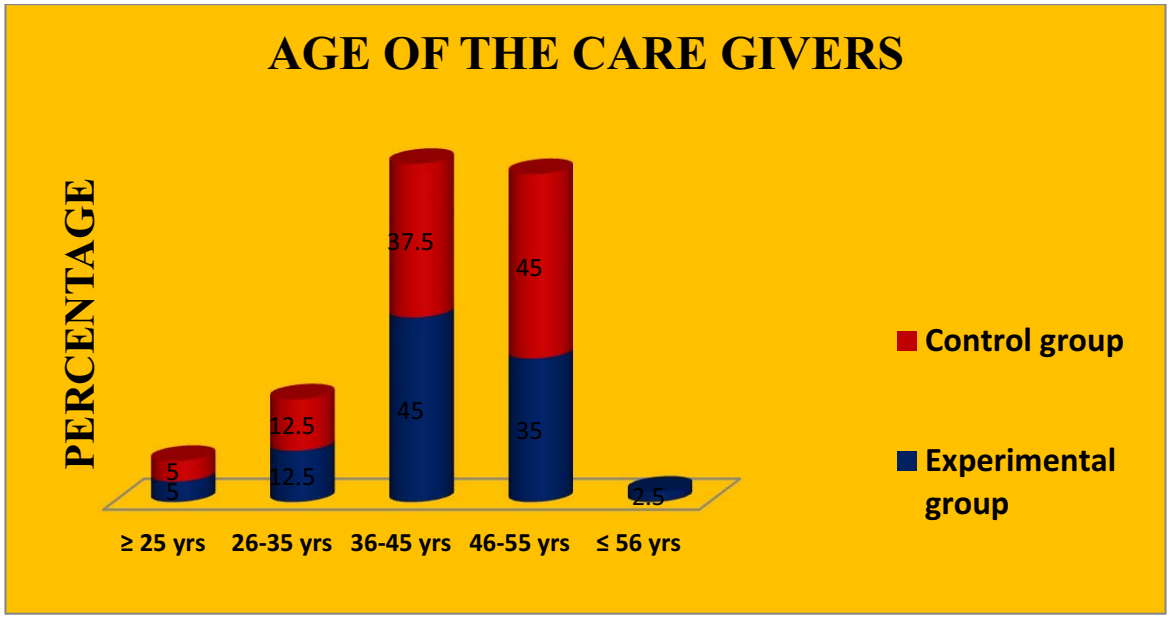


Figure4.2 Represents the percentage distribution sex of the care givers in experimental and control group.

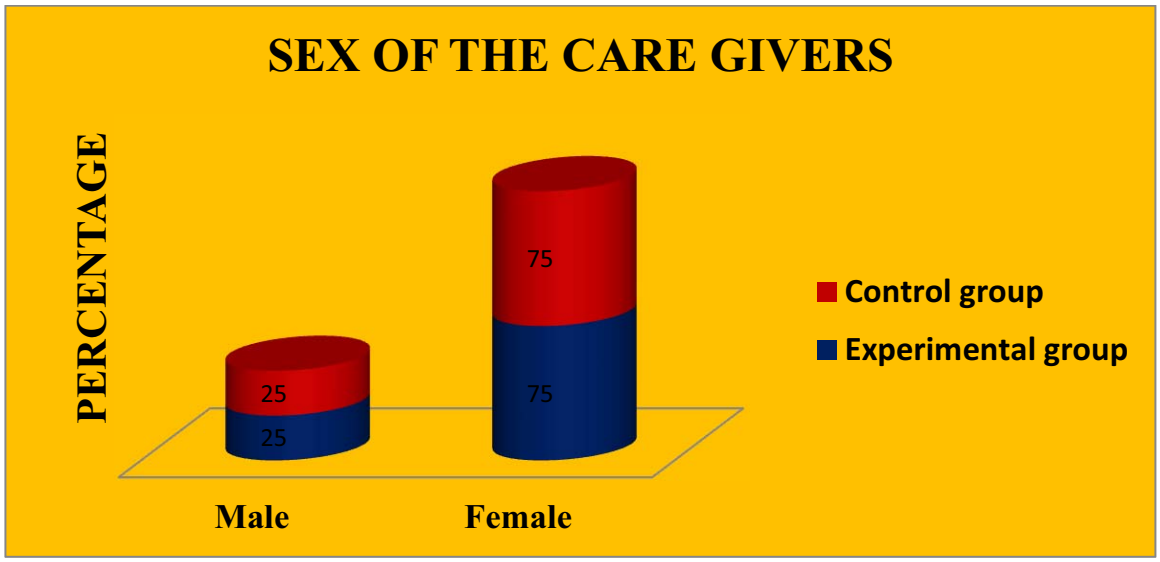


Figure 4.3 Represents the percentage distribution of relationship to the patient in experimental and control group.

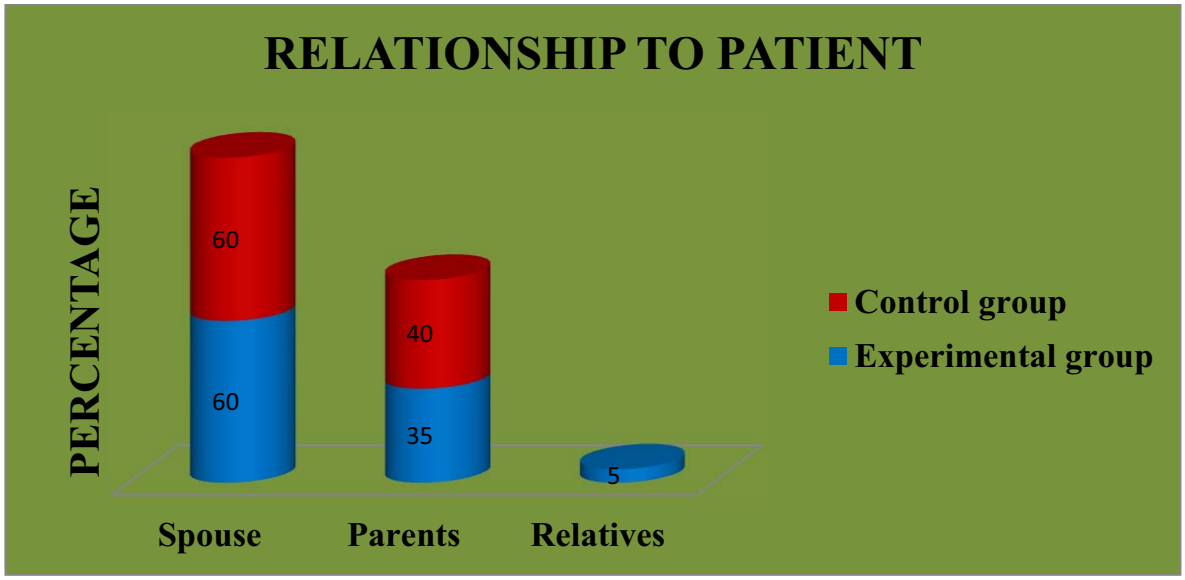


Figure 4.4 Represents the percentage distribution of education of the care givers in experimental and control group.

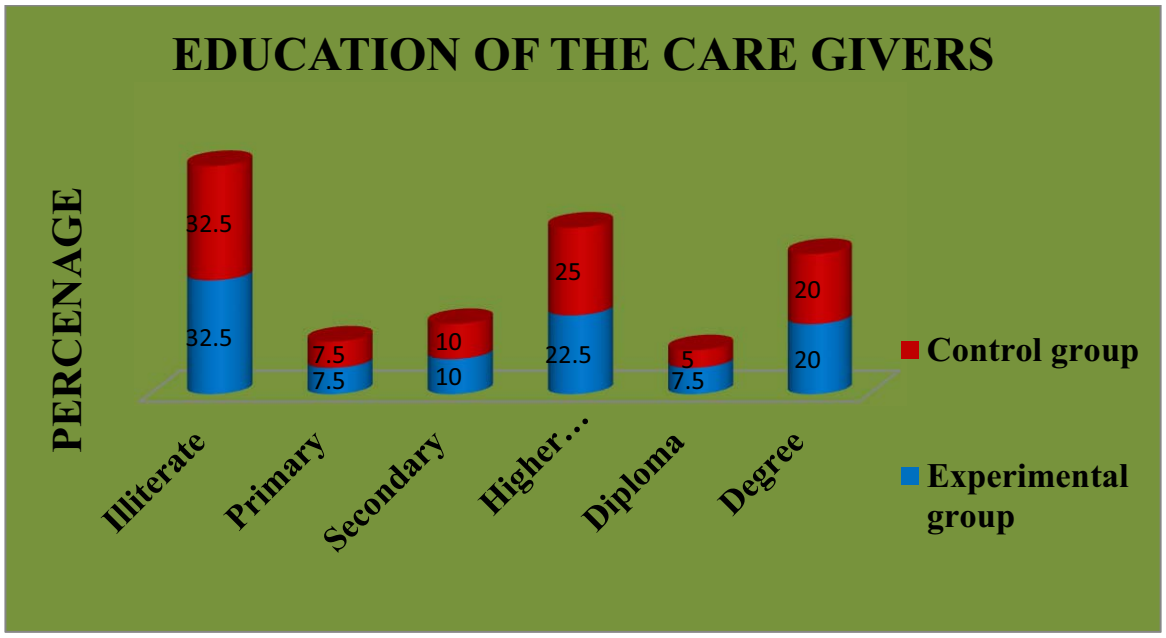


Figure 4.5 Represents the percentage distribution of Occupation of the care givers in experimental and control group.

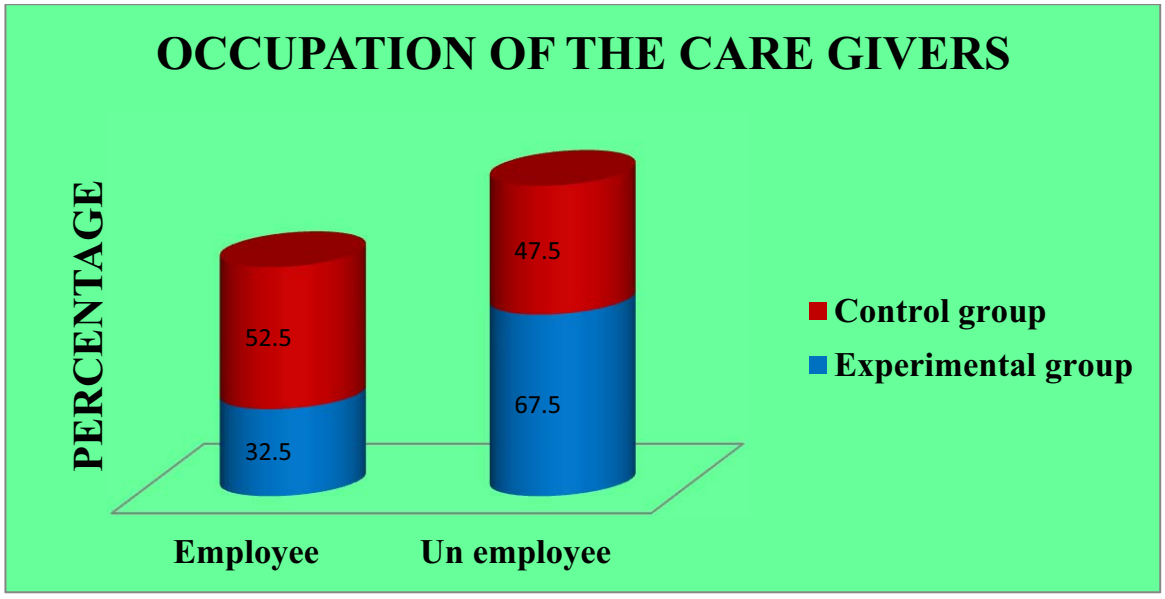


Figure 4.6 Represents the percentage distribution of Residential area of the care givers in experimental and control group.

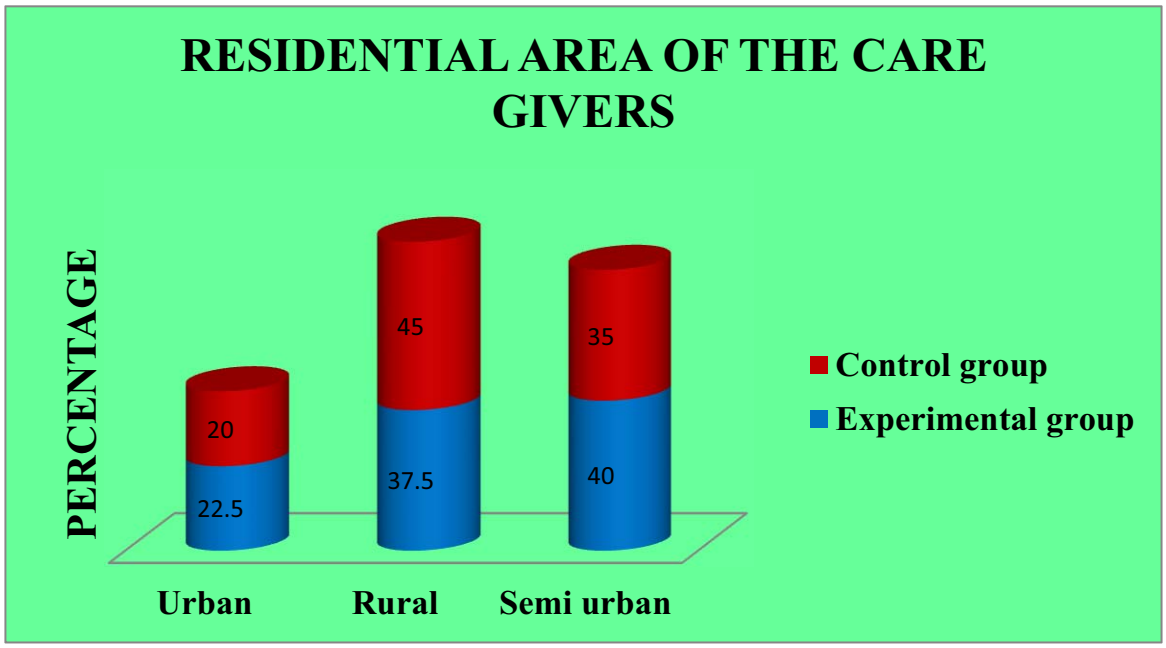


Figure 4.7 Represents the percentage distribution of duration of stay with the patient in experimental and control group.

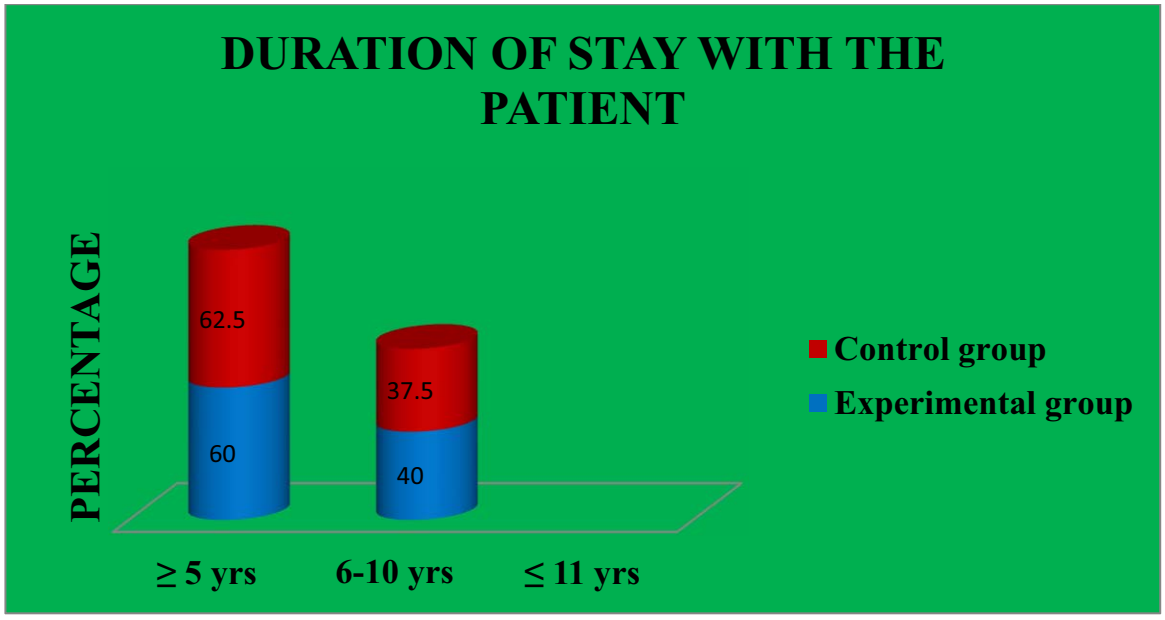
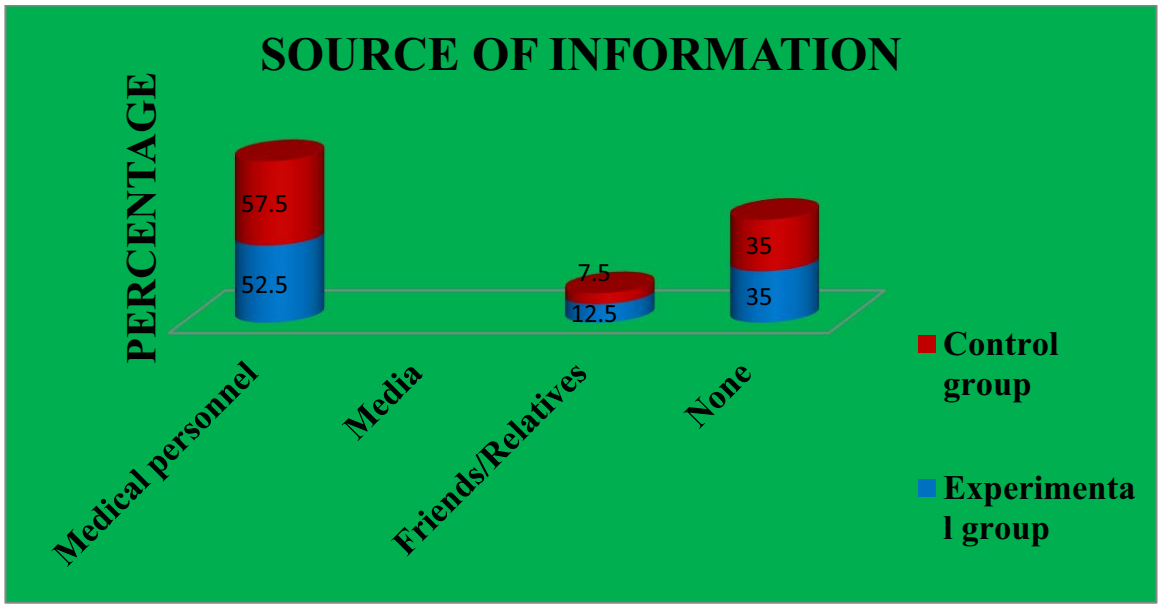


Figure 4.8 Represents the percentage distribution of source of information in experimental and control group.



SECTION: 2

Assessment of pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

TABLE: 4.2 Frequency and percentage distribution of pre test levels of knowledge among the care givers of mentally ill regarding ECT in both experimental and control group**.** **N=40+40=80**

LEVELS OF KNOWLEDGE	**EXPERIMENTAL GROUP**		**CONTROL GROUP**	
	Frequency (F)	**Percentage (%)**	**Frequency (F)**	**Percentage (%)**
Inadequate knowledge	28	70%	29	72.5%
Moderately adequate knowledge	12	30%	11	27.5%
Adequate knowledge	-	-	-	-

Table 4.2 represents the frequency and percentage distribution of pre test levels of knowledge among the care givers of mentally ill regarding ECT in both experimental and control group.

The assessment of pre test levels of knowledge regarding ECT revealed that 28 (70%) care givers had inadequate knowledge and 12 (30%) care givers had moderately adequate knowledge in experimental group. Where as in control group 29 (72.5%) care givers had inadequate knowledge and 11 (27.5%) care givers had moderately adequate knowledge and none of them had adequate knowledge in experimental and control group.

TABLE: 4.3

Frequency and percentage distribution of pre test levels of attitude among the care givers of mentally ill in both experimental and control group.

N=40+40=80

LEVELS OF ATTITUDE	**EXPERIMENTAL GROUP**		**CONTROL GROUP**	
	Frequency (F)	**Percentage (%)**	**Frequency (F)**	**Percentage (%)**
Inadequate attitude	33	82.5%	29	72.5%
Moderately adequate attitude	07	17.5%	11	27.5%
Adequate attitude	-	-	-	-

Table 4.3 represents the frequency and percentage distribution of pre test levels of attitude among the care givers of mentally ill regarding ECT in both experimental and control group.

The assessment of pre test levels of attitude regarding ECT revealed that 33 (82.5%) care givers had inadequate attitude and 15 (17.5%) care givers had moderately adequate attitude in experimental group. Where as in control group 29 (72.5%) care givers had inadequate attitude and 11 (27.5%) care givers had moderately adequate attitude and none of them had adequate attitude in experimental and control group.

SECTION: 3

Assessment of post test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

TABLE: 4.4 Frequency and percentage distribution of post test levels of knowledge among the care givers of mentally ill regarding ECT in both experimental and control group. **N= 40+40=80**

LEVELS OF KNOWLEDGE	**EXPERIMENTAL GROUP**		**CONTROL GROUP**	
	Frequency (F)	**Percentage (%)**	**Frequency (F)**	**Percentage (%)**
Inadequate knowledge	-	-	24	60%
Moderately adequate knowledge	11	27.5%	16	40%
Adequate knowledge	29	72.5%	-	-

Table 4.4 represents the frequency and percentage distribution of post test levels of knowledge among care givers of mentally ill regarding ECT in both experimental and control group.

The assessment of post test levels of knowledge regarding ECT revealed that 29 (72.5%) care givers had adequate knowledge and 11 (27.5%) care givers had moderately adequate knowledge and none of them had inadequate knowledge in experimental group. Where as in control group 24 (60%) care givers had inadequate knowledge and 16 (40%) care givers had moderately adequate knowledge and none of them had adequate knowledge in control group.

TABLE 4.5

Frequency and percentage distribution of post test levels of attitude among the care givers of mentally ill in both experimental and control group.

N=40+40=80

LEVELS OF ATTITUDE	**EXPERIMENTAL GROUP**		**CONTROL GROUP**	
	Frequency (F)	**Percentage (%)**	**Frequency (F)**	**Percentage (%)**
Inadequate attitude	-	-	27	67.5%
Moderately adequate attitude	14	35%	13	32.5%
Adequate attitude	26	65%	-	-

Table 4.5 represents the frequency and percentage distribution of post test levels of attitude among the care givers of mentally ill regarding ECT in both experimental and control group.

The assessment of post test levels of attitude regarding ECT revealed that 26(65%) care givers had adequate attitude and 14 (35%) care givers had moderately adequate attitude and none of them had inadequate attitude in experimental group. Where as in control group 27 (67.5%) care givers had inadequate attitude and 13 (32.5%) care givers had moderately adequate attitude and none of them had adequate attitude in control group.

SECTION: 4

Comparison of pre test and post test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

TABLE: 4.6

Comparison of pre and post test levels of knowledge regarding ECT among the care givers of mentally ill in both experimental and control group.

N=40+40=80

GROUP	PRE TEST		POST TEST		Paired "t" test value
	MEAN	SD	MEAN	SD	
Experimental group	10.1	3.9102	20.5	3.1384	t= 14.3428*
Control group	9.875	4.5065	11.15	3.8700	t = 2.0088

*= Significant

H0- there is no significant difference between the pre test and post test levels of knowledge regarding ECT among the care givers of mentally ill in experimental and control group.

TABLE: 4.6 Comparison of pre test and post levels of knowledge regarding ECT among the care givers of mentally ill in both experimental and control group.

The analysis revealed that the mean value was 10.1 with standard deviation 3.9102 for pre test has significant to the post test mean value was 20.5 with

Standard deviation 3.1384 and the calculated paired ‘t’ test value CV=14.3428 and the TV=2.0227 (CV>TV) which is significant at 0.05 level of the significant for experimental group. Where as in control group the analysis revealed that the mean value was 9.875 with standard deviation 4.5065 for pre test has significant to the post test mean was value 11.15 with standard deviation 3.8700 and the calculated paired ‘t’ test value CV= 2.0088 and the TV=2.0227 (CV<TV) which is not significant at, 0.05 level of significant for control group.

FIGURE 4.9 represents the comparison of pre test levels of knowledge regarding ECT among the care givers of mentally ill in both experimental and control group.

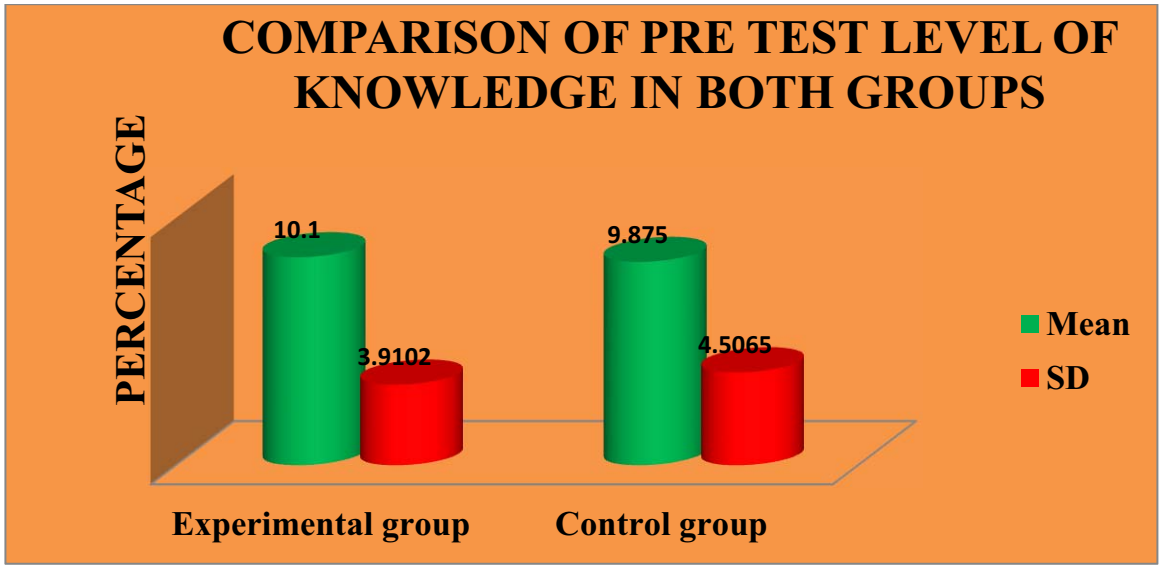


FIGURE 4.10 represents the comparison of post test levels of knowledge regarding ECT among the care givers of mentally ill in both experimental and control group.

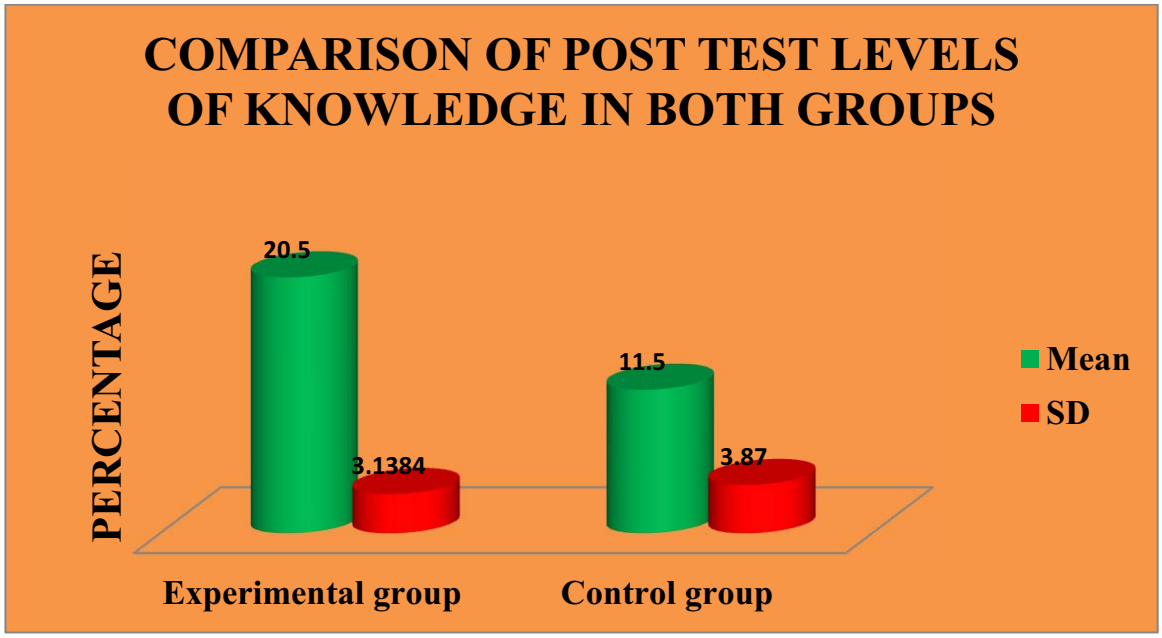


TABLE 4.7 Comparison of pre and post test levels of attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

GROUP	PRE TEST		POST TEST		Paired "t" test value
	MEAN	SD	MEAN	SD	
Experimental group	24.825	7.6186	48.7	14.3460	t = 9.4977*
Control group	24.95	8.6384	26.975	5.7466	t = 1.7873

* = Significant

H0- there is no significant difference between the pre test and post test levels of attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

TABLE: 4.7

Comparison of pre test and post levels of attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

The analysis revealed that mean was value 24.825 with standard deviation 7.6186 for pre test has significant to the post test mean value was 48.7 with standard deviation 8.6384 and the calculated paired 't' test value CV=9.4977 and the TV=2.0227 (CV>TV) which is significant at 0.05 level of significant for experimental group. Where as in control group the analysis revealed that mean value was 24.95 with standard deviation 8.6384 for pre test has significant to the post test mean value was 26.975 with standard deviation 5.7466 and the calculated paired 't' test value CV= 1.7873 and the TV=2.0227 (CV<TV) which is not significant at, 0.05 level of significant for control group.

FIGURE 4.11 represents the comparison of pre test levels of attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

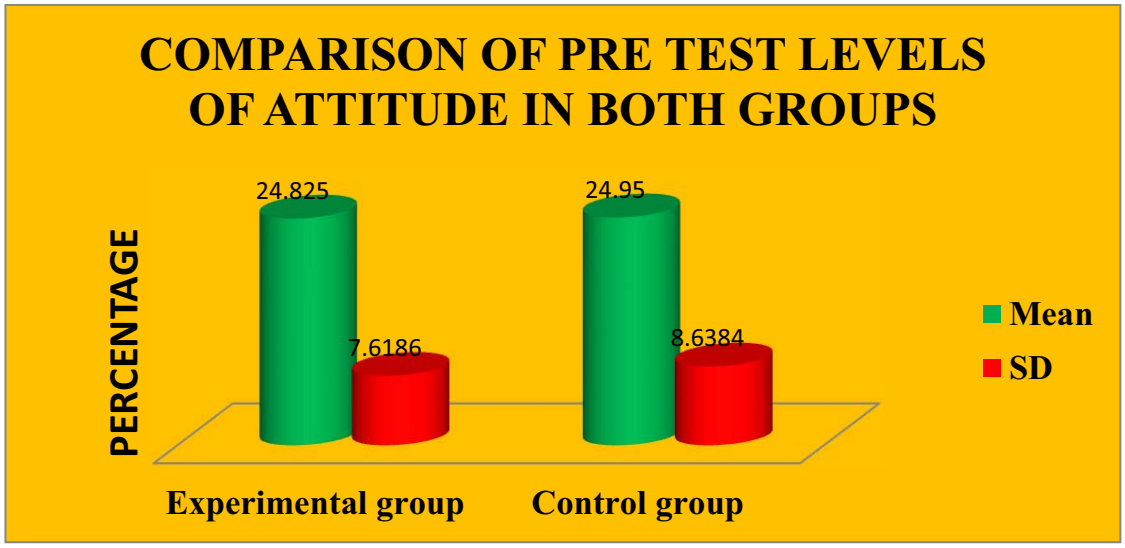
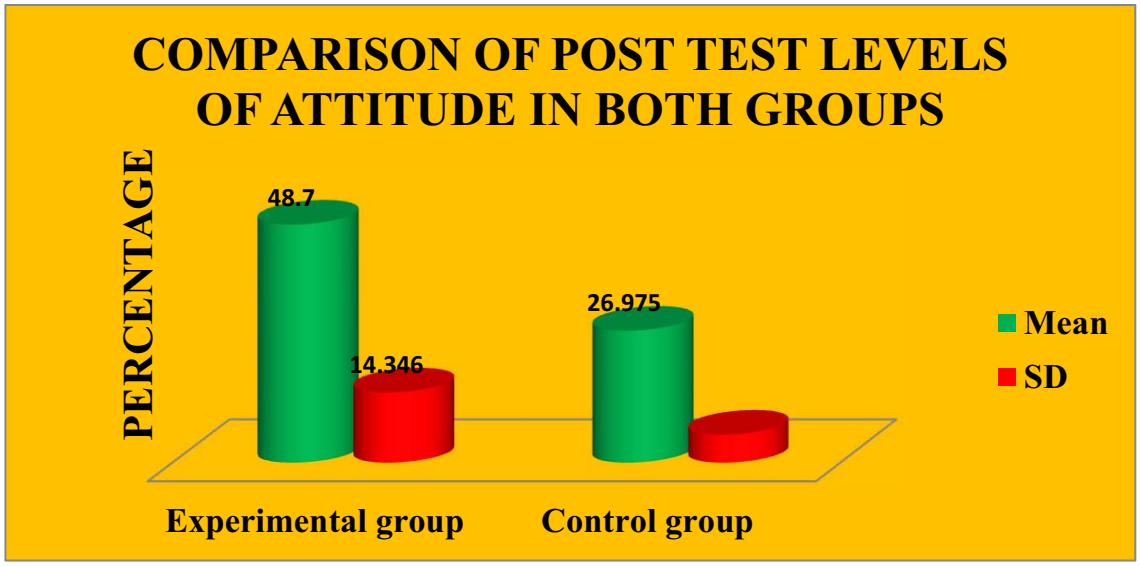


FIGURE 4.12 represents the comparison of post test levels of attitude regarding ECT among the care givers of mentally ill in both experimental and control group.



SECTION-5 Comparison of experimental and control group levels of knowledge and attitude regarding ECT among the care givers of mentally ill.

TABLE 4.8 Comparison of experimental and control group levels of knowledge regarding ECT among the care givers of mentally ill. **N=40+40=80**

TEST	**EXPERIMENTAL GROUP**		**CONTROL GROUP**		**Unpaired 't' test value**
	MEAN	**SD**	**MEAN**	**SD**	
PRE TEST	10.1	3.9102	9.875	4.5065	t = 0.1613
POST TEST	20.5	3.1384	11.15	3.8700	t = 11.7508*

*= Significant

H0- there is no significant difference the pre test and post test levels of knowledge between the experimental and control group.

TABLE: 4.8 Represents the comparison of experimental and control group levels of knowledge regarding ECT among the care givers of mentally ill.

The analysis revealed that the pre mean value was 10.1 standard deviation 3.9102 in experimental group and control group the mean value was 9.875 with standard deviation 4.5065 and the calculated unpaired 't' test value CV=0.1613 and the TV=2.0227(CV>TV) which is not significant at 0.05 level .

For the post mean value was 20.5 with standard deviation 3.1384 in experimental and in control group the mean value was 11.15 with standard deviation 3.8700 and the calculated unpaired 't' test value CV= 11.7508 and the TV=2.0227 (CV>TV) which is significant at 0.05 level .

FIGURE 4.13 represents the comparison of experimental and control group pre test levels of knowledge regarding ECT among the care givers of mentally ill.

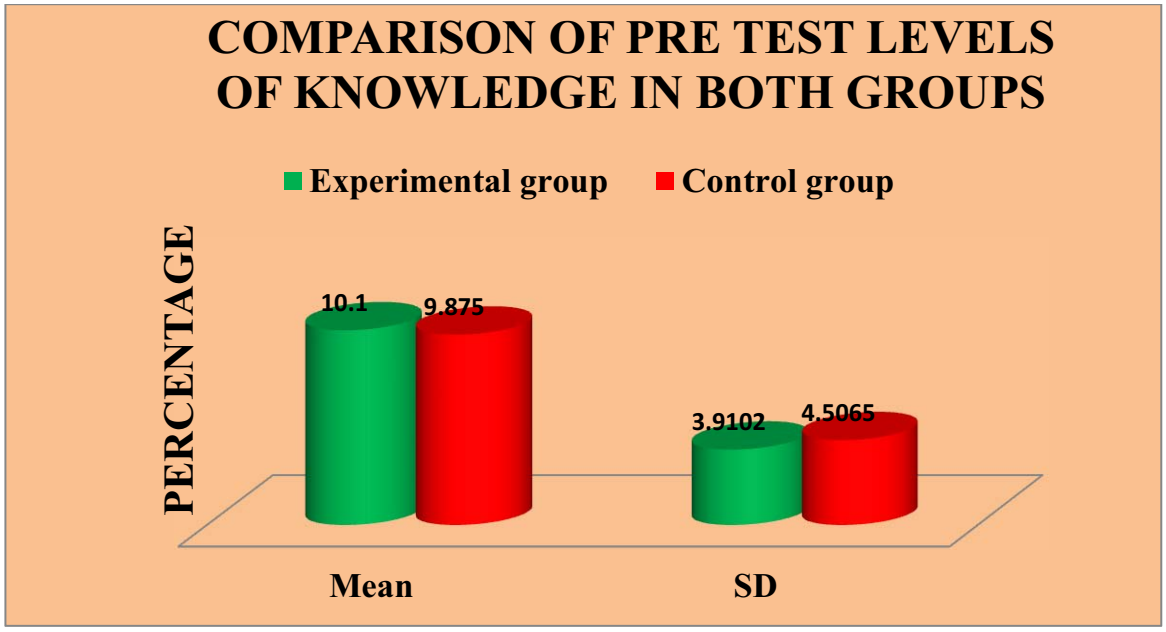


FIGURE 4.14 represents the comparison of experimental and control group post test levels of knowledge regarding ECT among the care givers of mentally ill.

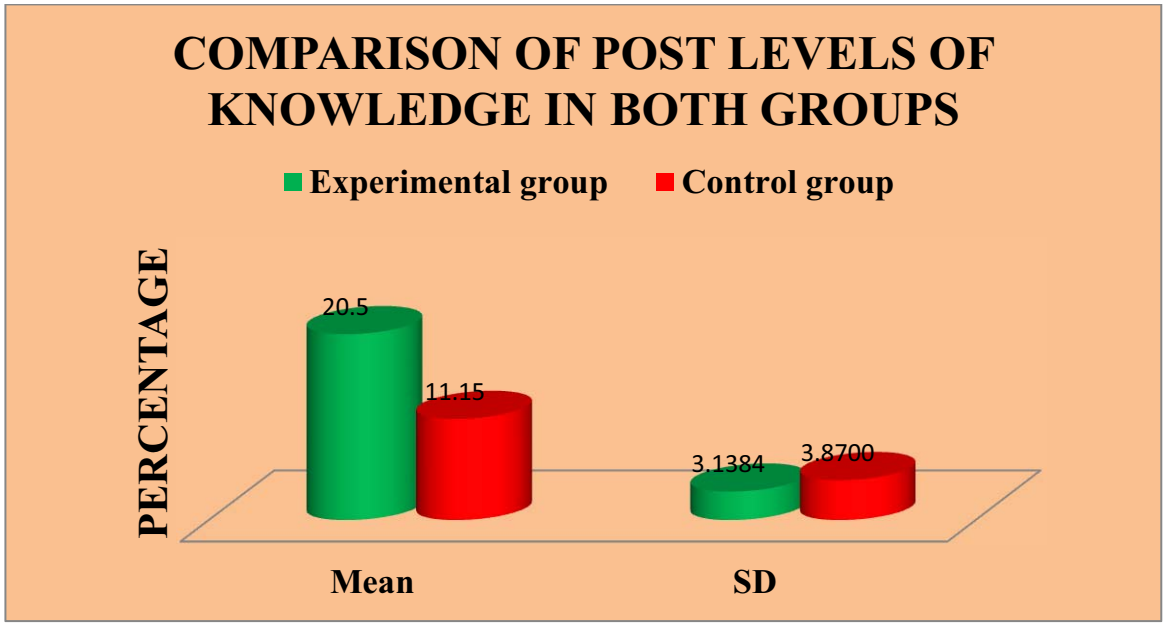


TABLE 4.9 Comparison of experimental and control group levels of attitude regarding ECT among the care givers of mentally ill.

N=40+40=80

TEST	**EXPERIMENTAL GROUP**		**CONTROL GROUP**		**Unpaired "t" test value**
	MEAN	**SD**	**MEAN**	**SD**	
PRE TEST	24.825	7.6186	24.95	8.6384	t = 0.0717
POST TEST	48.7	14.3460	26.975	5.7466	t = 8.7789*

*= Significant

H0- there is no significant difference the pre test and post test levels of attitude between the experimental and control group.

TABLE: 4.9 Represents the comparison of experimental and control group levels of attitude regarding ECT among the care givers of mentally ill.

The analysis revealed that mean value was 24.825 with standard deviation 7.6186 in experimental group and in control group the mean value was 24.95 with standard deviation 8.6384 and the calculated unpaired 't' test value CV=0.0717 and the TV=2.0227 (CV<TV) which is not significant at 0.05 level .

For the post mean value was 48.7 with standard deviation 14.3460 in experimental and in control group the mean value was 26.975 with standard deviation 5.7466 and the calculated unpaired 't' test value CV= 8.7789 and the TV=2.0227 (CV>TV) which is significant at 0.05 level .

FIGURE 4.15 represents the comparison of experimental and control group pre test levels of attitude regarding ECT among the care givers of mentally ill.

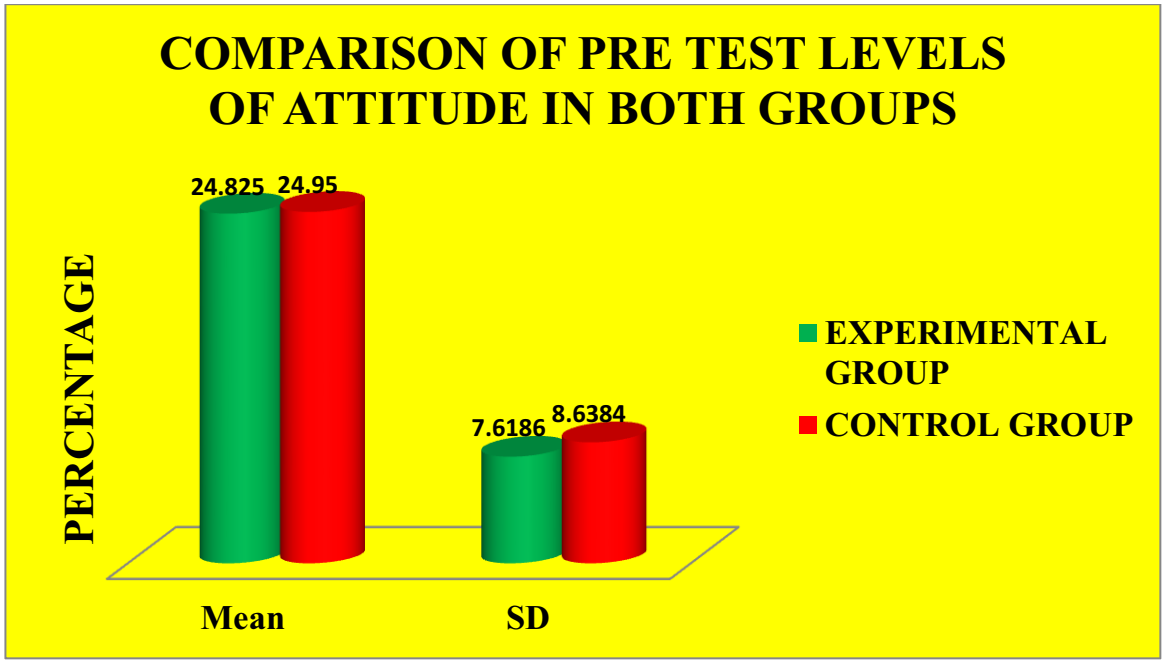
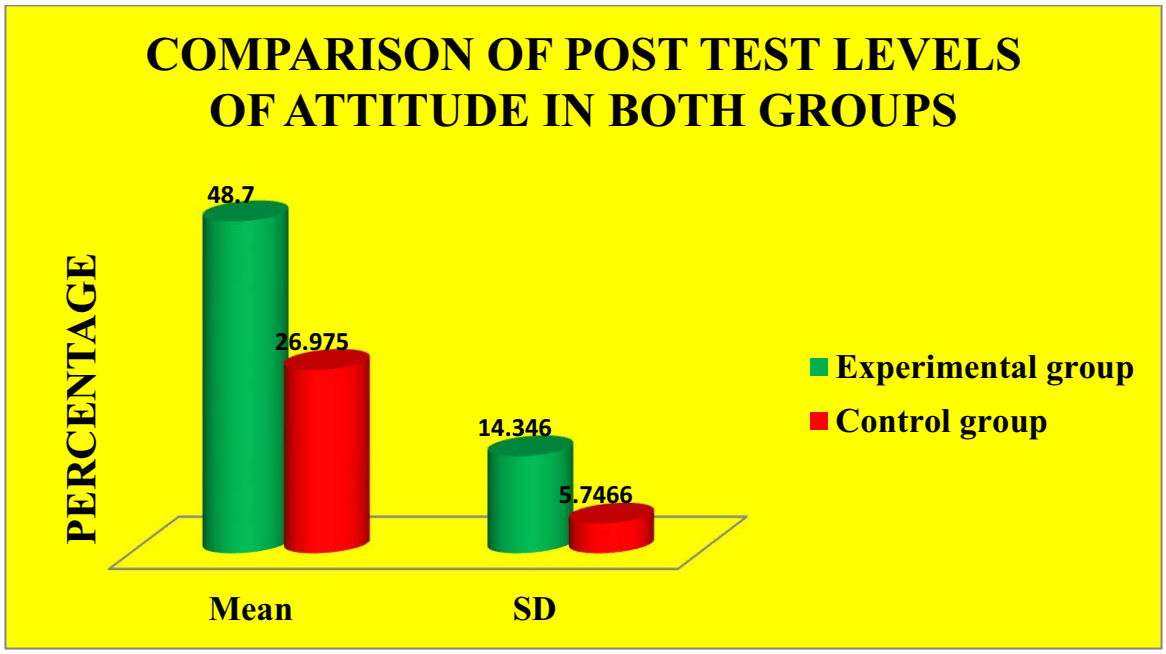


FIGURE 4.16 represents the comparison of experimental and control group post test levels of attitude regarding ECT among the care givers of mentally ill.



SECTION-6 Assessment of correlation between the post test scores of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

TABLE 4.10 Assess the correlation between the post test scores of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group.

GROUP	**POST TEST**		**POST TEST**		**'r' value**
	MEAN	**SD**	**MEAN**	**SD**	
Experimental group	20.5	3.1384	48.7	14.3460	0.8 Positive and highly significance
Control group	11.15	3.8700	26.975	5.7466	0.3 Positive and moderate significance

TABLE 4.10 represents the correlation between the post test scores of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group. In experimental group the mean value of knowledge represented 20.5 with standard deviation 3.1384 and the mean value of attitude 48.7 with standard deviation 14.3460 and the correlation r=0.8095 which was indicated positive and highly significance relationship for post test scores. where as in control group the mean value of knowledge 11.15 with standard deviation 3.8700 and the mean value of attitude 26.975 with standard deviation 5.7466 and the correlation r=0.3145 which was indicated positive and moderately significant correlation between the knowledge and attitude of experimental group.

SECTION: 7

Assessment of the association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental and control group with their selected demographic variables.

TABLE 4.11 Association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in both experimental group with their selected demographic variables**.** **N=40**

Demographic variables	**Level of knowledge**							**Level of attitude**						
	Inadequate		**Moderately adequate**		**Adequate**			**Inadequate**		**Moderate adequate**		**Adequate**		
	NO	**%**	**NO**	**%**	**NO**	**%**		**NO**	**%**	**NO**	**%**	**NO**	**%**	
Age														
≥25 yrs	02	05	0	0	-	-		02	05	0	0	-	-	
26-35 yrs	04	10	01	2.5	-	-	2.67	04	10	01	2.5	-	-	3.186
z36-45 yrs	13	32.5	05	12.5	-	-	8	14	35	04	10	-	-	
46-55 yrs	08	20	06	15	-	-		08	20	06	15	-	-	
≤56 yrs	01	2.5	0	0	-	-		01	2.5	0	0	-	-	
Gender														
Male	07	17.5	10	25	-	-	0	07	17.5	03	7.5	-	-	0.041
Female	21	52.5	30	75	-	-		22	55	08	20	-	-	
Relationship to patient														

Spouse	18	45	06	15	-	-	0.99	18	45	06	15			1.3074
Parents	09	22.5	05	12.5	-	-	09	09	22.5	05	12.5	-	-	
Others	01	2.5	01	2.5	-	-		02	05	0	0	-	-	
												-	-	
Education														
Illiterate	13	32.5	0	0	-	-		13	32.5	0	0	-	-	
Primary	01	2.5	02	05	-	-		02	05	01	2.5	-	-	
Secondary	03	7.5	01	2.5	-	-	8.20	03	7.5	01	2.5	-	-	10.114
Higher	06	15	03	7.5	-	-	98	06	15	03	7.5	-	-	1
secondary														
Diploma	02	05	01	2.5	-	-		02	5	01	2.5	-	-	
Degree	03	7.5	05	12.5	-	-		03	7.5	05	12.5	-	-	
Occupation														
Employed	03	7.5	10	25	-	-	20.1	05	12.5	08	20	-	-	13.494
Un employed	25	62.5	02	05	-	-	825	24	60	03	7.5	-	-	2*
							*							
Area of residence														
Urban	05	12.5	04	05	-	-	2.06	06	15	03	7.5	-	-	1.0299
Semi urban	10	25	05	12.5	-	-	38	10	25	05	12.5	-	-	
Rural	13	32.5	03	7.5	-	-		13	32.5	03	7.5	-	-	
Duration of stay with the patient														
≥5 yrs	24	60	0	0	-	-	25.7	14	35	10	25	-	-	5.043
6-10 yrs	04	10	12	30	-	-	142	15	37.5	01	2.5	-	-	
≤11 yrs	-		-	-	-	-	*	-	-	-	-	-	-	

Previous source of information														
Medical personnel	11	27.5	10	25	-	-	9.34	10	25	11	27.5	-	-	13.721
Mass media	-	-	-	-	-	-	22	-	-	-	-	-	-	1 *
Friends/ relatives	03	7.5	02	05	-	-		05	12.5	0	0	-	-	
None	14	35	0	0	-	-		14	35	0	0	-	-	

*= Significant

H0 there is no significant association between the pre test level of knowledge and attitude regarding ECT among the care givers of mentally ill in experimental group with their selected demographic variables.

TABLE 4.11 showed the association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in experimental group with their selected demographic variables.

The analysis revealed that there was a significant association between the occupation and duration of stay with the patient pre test levels of knowledge and there was no significant association between the age of the care givers, sex, relationship to patient, education, area of residence, and source of information in experimental group. Where as in pre test levels of attitude revealed that there was a significant association between the occupation and source of information pre test levels of attitude and there was no significant association between the age of the care givers, age, relationship to patient, education, area of residence and duration of stay with the patient in experimental group at the significance of 0.05 level.

TABLE 4.12 Association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in control group with their selected demographic variables. **N=40**

Demographic variables	**Level of knowledge**							**Level of attitude**						
	Inadequate		**Moderately adequate**		**Adequate**			**Inadequate**		**Moderate adequate**		**Adequate**		
	NO	**%**	**NO**	**%**	**NO**	**%**		**NO**	**%**	**NO**	**%**	**NO**	**%**	
Age														
≥25 yrs	01	2.5	-	-	-	-	2.66	02	05	01	2.5	-	-	2.90
26-35 yrs	05	12.5	01	2.5	-	-	07	04	10	03	7.5	-	-	3
36-45 yrs	10	15	0	0	-	-		08	20	06	15	-	-	
46-55 yrs	13	32.5	05	12.5	-	-		13	32.5	03	7.5	-	-	
≤56 yrs	-	-	05	12.5	-	-		-	-	-	-	-	-	
Sex														
Male	07	17.5	05	12.5	-	-	0.04	06	15	04	05	-	-	0.34
Female	22	55	07	17.5	-	-	16	21	52.5	09	22.5	-	-	16
Relationship to patient														
Spouse	20	50	04		-	-	3.53	18	45			-	-	7.46
Parents	09	22.5	07	05	-	-	17	09	22.5	06	15	-	-	42
Others	-	-	-	17.5				-		07	17.5			
										-				
Education														
Illiterate	13	32.5	0	0	-	-		13	32.5	0	0	-	-	

Primary	02	05	01	2.5	-	-		01	2.5	02	05	-	-	
Secondary	03	7.5	01	2.5	-	-	11.4	03	7.5	01	2.5	-	-	11.5
Higher	06	15	04	10	-	-	518	06	15	04	10	-	-	881
secondary														
Diploma	02	05	0	0	-	-		01	2.5	01	2.5	-	-	
Degree	03	7.5	05	12.5	-	-		03	7.5	05	12.5	-	-	
Occupation														
Employed	08	20	05	12.5	-	-	7.43	05	12.5	08	20	-	-	7.40
Un	21	52.5	06	15	-	-	7*	22	55	05	12.5	-	-	28*
employed														
Area of residence														
Urban	06	15	02	05	-	-	0.75	05	12.5	03	7.5			0.17
Rural	14	35	04	10	-	-		13	32.5	05	12.5			64
Semi urban	09	22.5	05	12.5	-	-		09	22.5	05	12.5			
Duration of stay with the patient														
≥5 yrs	20	50	05	12.5			1.88	19	47.5	06	15	-	-	1.52
6-10 yrs	09	22.5	06	15			06	08	20	07	17.5	-	-	07
≤11 yrs	-		-					-	-	-	-	-	-	

Previous source of information														
Medical personnel	12	30	11	27.5	-	-		11	27.5	12	30	-	-	
Mass media	-	-	-	-	-	-	11.2	-		-		-	-	10.7
Friends/ relatives	03	7.5	0	0	-	-	141	02	05	01	2.5	-	-	995
None	14	35	0	0	-	-		14	35	0	0	-	-	

*= Significant

H0 there is no significant association between the pre test level of knowledge and attitude regarding ECT among the care givers of mentally ill in control group with their selected demographic variables.

TABLE 4.12 showed the association between the pre test levels of knowledge and attitude regarding ECT among the care givers of mentally ill in control group with their selected demographic variables. The analysis revealed that there was a significant association between the occupation of pre test levels of knowledge and there is no significant association between the age of the care givers, sex, relationship to patient, education, area of residence, duration of stay with the patient and source of information in control group. Where as in pre test levels of attitude revealed that there was a significant association between the occupation of pre test levels of attitude and there is no significant association between the age of the care givers, sex, relationship to patient, education, occupation, area of residence, duration of stay with the patient and source of information in control group at the significant level of 0.05.

CHAPTER – V

DISCUSSION

CHAPTER – V

DISCUSSION

This chapter deals about the discussion of the study with appropriate statistical analysis and the findings of the study based on the objectives and hypothesis of the study.

The study was a quasi experimental (non- equivalent pre test post test control group) design. The problem stated as an "A study to assess the effectiveness of psycho education on knowledge and attitude regarding ECT among the care givers of mentally ill at selected hospitals, Trichy."

The study was conducted for 80 care givers in which 40 are assigned to experimental group and 40 are assigned to control group. An interview was conducted to assess the knowledge and assess the attitude by semi structured knowledge questionnaire and 5 point Likert scale used to assess the attitude among the care givers of mentally ill at selected hospitals at, Trichy. After pre test the psycho education was provided to the experimental group by the investigator. After 7 days from the pre test, post test was conducted by using same knowledge questionnaire for both experimental and control group. The data was grouped and analysed using descriptive and inferential statistics.

The first objective to assess the knowledge and attitude regarding ECT among the care givers of mentally ill in experimental and control group.

In the experimental group level of knowledge was 28 (70%) care givers had inadequate knowledge and 12 (30%) of care givers had moderately adequate knowledge. In attitude 33(82.5%) care givers had inadequate attitude and 7(17.5%) care givers had moderately adequate attitude and none of them had adequate knowledge and attitude regarding ECT.

In the control group the level of knowledge was 29 (72.5%) care givers had inadequate knowledge and 11(27.5%) care givers had moderately adequate knowledge. In attitude 29 (72.5%) care givers had inadequate attitude and 11(27.5%) of care givers had moderately adequate attitude and none of them had adequate attitude in experimental and control group.

The second objective to evaluate the effectiveness of psycho education regarding ECT among the care givers of mentally ill in experimental group.

In experimental group the mean pre test value of knowledge was 10.1with standard deviation 3.9102, In post mean value 20.5 with standard deviation 3.1384. Which was found to projected 't' value CV = 14.3428 and the TV=2.0227(CV>TV) which is significant at 0.05 level . Where as in pre test level of attitude the mean value was 24.825 with standard deviation 7.6186, in post test mean value was 48.7 with standard deviation 14.3460, which was found to projected 't' value CV = 9.4977 and the TV= 2.0227 (CV<TV) at 0.05 level. It proves that there is a significant difference between the pre and post test level of knowledge and attitude regarding ECT in experimental group so psycho education was effective.

In control group the mean pre test value of knowledge was 9.875 with standard deviation 4.5065, In post mean value 11.5 with standard deviation 3.8700. which was found to projected 't' value CV = 2.0088 and the TV=2.0227(CV>TV) which is not significant at 0.05 level .where as in pre test level of attitude the mean value was 24.95 with standard deviation 8.6384, in post test mean value was 26.975 with standard deviation 5.7466, which was found to projected 't' value CV = 1.7873 and the TV= 2.0227 (CV<TV) at 0.05 level. It proves that there is a no significant difference between the pre and post test level of knowledge and attitude regarding ECT.

Hence the research hypothesis H1 states that there is a significant difference in the pre and post test knowledge and attitude regarding ECT among the care givers of mentally ill was accepted with the experimental group and same it is rejected to the knowledge and attitude of the control group.

The above mentioned statistical analysis proves that the selected psycho education was very effective to the experimental group.

The third objective to compare the pre and post test scores of knowledge and attitude between the experiment and control group.

In experimental group the mean pre test value of knowledge was 10.1with standard deviation 3.9102, In control group pre test mean value of knowledge was 9.875 with standard deviation 4.5065, which was found to projected unpaired 't' value CV = 0.1613 and the TV=2.0227(CV>TV) which is not significant at 0.05 level . where as in pre test level of attitude the mean value was 24.825 with standard deviation 7.6186, where as in control group 84, which was found to projected unpaired 't' value CV= 0.0717 and the TV= 2.0227 (CV<TV) which is not significant at 0.05 level.

In experimental group the mean post test value of knowledge was 20.5with standard deviation 3.1384, In control group post test mean value of knowledge was 11.15with standard deviation 3.8700, which was found to projected unpaired 't' value CV = 12.4029 and the TV=2.0227(CV>TV) which is significant at 0.05 level . where as in post test level of attitude the mean value was 48.7 with standard deviation 14.3460, where as in control group post test level of attitude the mean value was 26.975 with standard deviation 5.7466, which was found to projected unpaired 't' value CV= 8.3178 and the TV= 2.0227 (CV>TV) which is significant at 0.05 level.

Research hypothesis H2 states that there is a significant difference in the scores of knowledge and attitude between the experimental and control

group regarding ECT among the care givers. Hence the research hypothesis H2 was accepted but the same it is rejected to the pre test scores of knowledge and attitude of the experimental and control group.

The above mentioned statistical analysis proves that the experimental group was effective than the control group.

In the fourth objective to correlate the knowledge and attitude regarding ECT among the care givers of mentally ill in experimental and control group.

In experimental group post test scores of knowledge mean value is 20.5 with standard deviation 3.1384 and the mean value of attitude 48.7 with standard deviation 14.3460 and the correlation r=0.8095 it revealed that there was a positive and highly significant correlation between the knowledge and attitude regarding ECT. In control group the mean post test scores of knowledge 11.15 with standard deviation 3.8700 and the mean value of attitude 26.975 with standard deviation 5.7466 and the correlation r=0.3145 it revealed that there is a positive and moderately significant correlation between the knowledge and attitude regarding ECT.

So the hypothesis H3 there will be a significant correlation between the post test scores of knowledge and attitude regarding ECT among the care givers of mentally ill in experimental group control group is accepted.

In the fifth objective to determine the pre test knowledge and attitude regarding ECT among the care givers of mentally ill and their selected demographic variables.

In the experimental group that there is no significant association in the age of the care givers, sex, relationship to patient, education, area of residence, and source of information towards the pretest knowledge level. Where as in attitude there is no significant association in the age, relationship to patient,

Education, area of residence and duration of stay with the patient. So the hypothesis is rejected.

In the control group there was no significant association in the age of the care givers, sex, relationship to patient, education, area of residence, duration of stay with the patient and source of information towards the pretest knowledge level .where as in attitude there is no significant association in the age of the care givers, sex, relationship to patient, education, occupation, area of residence, duration of stay with the patient and source of information. So the hypothesis H4 is rejected.

But in the same experiment group there was a significant association between the occupation and duration of stay with the patient in the level of knowledge. And there was a significant association in the occupation and source of information in the level of attitude so H4 is accepted. Where as in control group there was a significant association in the occupation of level of knowledge and there was a significant association in the occupation in the level of attitude so H4 is accepted.

CHAPTER- VI

SUMMARY
CONCLUSION

CHAPTER – VI

SUMMARY AND CONCLUSION

SUMMARY

The present study was conducted to assess the knowledge and attitude of the care givers regarding ECT. The design was quasi experimental design. A total 80 care givers (40 care givers experiment group and 40 care givers control group) who meet the inclusion and exclusion criteria were selected as samples from the selected hospitals, Trichy. The samples were selected by using convenient sampling technique. The investigator first introduced herself to the samples and developed rapport with them. After the selection of samples, the interview was being conducted with the instrument.

In the experimental group level of knowledge was 28 (70%) of care givers had inadequate knowledge and 12 (30%) of care givers had moderately adequate knowledge. In attitude 33(82%) care givers had inadequate attitude and 7(17.5%) care givers had moderately adequate attitude and none of them had adequate knowledge and attitude regarding ECT.

In the control group the level of knowledge was 29 (72.5%) of care givers had inadequate knowledge and 11 (27.5%) of care givers had moderately adequate knowledge. In attitude 29 (72.5%) of care givers had inadequate attitude and 11(27.5%) of care givers had moderately adequate attitude and none of them had adequate attitude in experimental and control group.

In the post test experimental group level of knowledge was 29 (72.5%) of care givers had adequate knowledge and 11 (27.5%) of care givers had moderately adequate knowledge and none of them had inadequate knowledge in experimental group. In attitude 26(65%) of care givers had adequate attitude and 14 (35%) of care givers had moderately adequate attitude and none of them had inadequate attitude in experimental group.

In the post test control group level of knowledge 24 (60%) of care givers had inadequate knowledge and 16 (40%) of care givers had moderately adequate knowledge and none of them had adequate knowledge. In attitude 27 (67.5%) of care givers had inadequate attitude and 13 (32.5%) of care givers had moderately adequate attitude and none of them had adequate attitude in control group regarding ECT.

The statistical analysis reveals the knowledge and expressed practice of the experiment group was calculated by the paired‘t’ test for knowledge (‘t’ = 14.3428) and for attitude (‘t’ = 9.4977). This proves that there was a significant difference in pre test and post test levels of knowledge and attitude for the experiment group at 0.05 level. Where as in control group the knowledge level was (‘t’ = 2.0088) indicates no difference in knowledge and for attitude (‘t’ = 1.7873) was revealed there was no difference in pre and post test attitude for the control group at 0.05 level. So the Psycho education was effective.

The statistical analysis for the comparison of knowledge and attitude of the experiment group and the control group was calculated by the unpaired ‘t’ test for pre test knowledge (‘t’ = 0.1613) it showed no difference in knowledge and for attitude (‘t’ = 0.0717). This proved that there is a no significant difference in attitude. Where as in post test the knowledge level was (‘t’ = 11.7508) and for attitude (‘t’ = 8.7789) this revealed that there is a significant difference in post test knowledge and attitude for the experiment and control group.

The statistical analysis for correlation between the post test scores of knowledge and attitude of the experiment and control group was calculated by “Karl Pearson correlation test” stated that in experimental group the post test scores of knowledge mean value is 20.5 with SD 3.1384 and the post test scores of attitude the mean value is 48.7 with SD 14.3460. And the ‘r’ value (r = 0.8095) it revealed that there is a positive and highly significant correlation between the knowledge and attitude regarding ECT. In control group the mean

post test value of knowledge was 11.15 with SD 3.8700 and in attitude the mean value 26.975 with SD 5.7466 an 'r' value (0.3145) it revealed that there was a positive and moderate significant correlation between the knowledge and attitude regarding ECT.

The statistical analysis to determine the association between the pre test levels of knowledge and attitude regarding ECT among the care givers with their selected demographic variables was calculated by using 'chi square test'. The results were stated that in experiment group towards the knowledge there was a significant association with relationship to patient and occupation and in attitude there is a significant association with duration of stay with the patient and source of information. Where as in control group towards the knowledge level there is a significant association with occupation and in attitude there is a significant association with occupation.

CONCLUSION

The main objective of the study was to determine the effectiveness of Psycho education on knowledge and attitude regarding ECT among the care givers of mentally ill at selected hospitals, Trichy. The statistical analysis revealed that there is a significant difference between the pre test and post test levels of knowledge and attitude of experiment group indicated the given Psycho education was effective.

NURSING IMPLICATIONS

The findings of the study have certain important implications for the nursing service, education, administration, and nursing research.

NURSING SERVICE

Nurses are act as an educator, leader, supervisor, protector, advocator and team member in various situation of work. Education given to the care givers of mentally ill and public regarding ECT to eliminate the ignorance and create the awareness. The finding of the study will help the care givers to identify and provide efficient care to the patient.

NURSING EDUCATION

The result of the study will help to the nurse educator to import the knowledge regarding ECT to the care givers.

The study emphasis the need of educating the nursing personnel, non nursing personnel and the public through in- service education or continuing education programme to update their knowledge and attitude in educating the care givers regarding ECT.

NURSING RESEARCH

The study can be baseline for further studies to built upon

The study can be conduct in various group of psychiatric patients, care givers of mentally ill, health professionals and to the public.

NURSING ADMINISTRATION

The finding of the present study will help the nurses to organize and plan for educational programme by using various teaching methods and audiovisual aids.

RECOMMENDATION

- The comparative study can also be done to assess the effectiveness of Psycho education among care givers of mentally ill.

- The study can be done on large sample size to generalize the effectiveness Psycho education.
- An experiment study can be done to assess the effectiveness of Psycho education regarding ECT among the general public.

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REFERENCES

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ANNEXURE

REQUISITION FOR VALIDITY

From

Ms. P.DURGA DEVI , II year MSc(N),

Our Lady Of health College Of Nursing,

Thanjavur**.**

Through Principal,

To

Respected sir/Madam,

Subject : Requisition for content validity regarding.

I am M.Sc Nursing student of Our Lady Of Health College Of Nursing, Thanjavur. As part of my course, I am doing a study on the topic mentioned below.

TOPIC: "A study to assess the effectiveness of Psycho education on knowledge and attitude regarding ECT among the care givers of mentally ill at selected hospitals, Trichy"

May I request you to go through and validate the content regarding Psycho education regarding ECT among the care givers of mentally ill. Please enlighten me with your valuable suggestions for modifying the tools and psycho education .

Thanking you in anticipation,

Place: Yours sincerely,

Date: Ms.P.DURGA DEVI

LIST OF EXPERTS

1. Dr.G.Gopalakrishnan,M.D(Psych),
   Consultant psychiatrist,
   Sowmanasya psychiatric hospital,
   Trichy.
2. Dr. Arunkumar, M.D(Psych),
   Consultant psychiatrist,
   Athma psychiatric hospital,
   Trichy.
3. Mr. P.Rama Reddy,M.Sc(N),
   Senior nursing tutor,
   NIMHANS,
   Bangalore.
4. Mr. R.Francis moses, M.Sc(N),
   Associate professor cum principal,
   St.Xavier College of nursing,
   Kumbakonam.
5. Mrs.P.Devi, M.Sc(N),
   Reader,
   Sacred heart college of nursing,
   Kumbakonam.

RESEARCH TOOL

TOOL-1 DEMOGRAPHIC VARIABLES

SAMPLE NO :

HOSPITAL :

Samples are requested to kindly tick the options

1. Age of the care givers

   a. ≥ 25 years

   b. 26-35 years

   c. 36-45 years

   d. 46-55 years

   e. ≤ 56 years

2.Sex

   a. Male

   b. Female

3. Relationship to patient

   a. Spouse

   b. Parents

   c. others

4.Education

a. Illiterate

b. Primary

c. Secondary

d. Higher secondary

e. Diploma

f. Degree

5.Occupation

a. Employed

b. Un employed

c. Home maker

d. Retired

6.Area of residence

a. Rural

b. Semi urban

c. Urban

7.Duration of stay with the patient

a.≤ 5 yr

b.6-10 yrs

c. ≥ 11 yrs

8.Previous source of information

a. Health professional

b. Mass media

c. Friends

d. relatives

e. None

TOOL-2 KNOWLEDGE OF CARE GIVERS REGARDING ELECTRO CONVULSIVE THERAPY

1.What is meant by Electro convulsive therapy?

a. Application of electrical impulses

b. Psychotherapy

c. drug therapy

2.Who can administer Electro convulsive therapy?

a. Nurse

b. Psychiatrist

c. Clinical psychologist

3. How often is Electro convulsive therapy given per week?

a. 5 times

b. 1 time

c. 3 times

4.How many Electro convulsive therapy the clients required an average?

a.5-10 treatments

b. 10-15 treatments

c. 6-12 treatments

5.How is Electro convulsive therapy given?

a. By injection

b. By special machine

c. By medicine

6.How does the Electro convulsive therapy works?

a. Correcting renal changes

b. Correcting cardiac changes

c. Correcting brain changes

7.What is the indication for Electro convulsive therapy ?

a. Major depression

b. Cardiac patient

c. Older patient

8.Who are contra indicated for receiving Electro convulsive therapy?

a. Renal patient

b. Older patient

c. Cardiac patient

9.What are the common side effects for Electro convulsive therapy?

a. Temporary memory loss

b. Diarhoea

c. Heart attack

10.Which is the most important investigations for before giving Electro convulsive therapy ?

a. Blood sugar and ECG

b. Haemoglobin test and urine test

c. CT scan and MRI

11.What is the ideal time for Electro convulsive therapy?

a. Evening

b. Morning

c. Night

12.How long the patient maintain NPO for before treatment?

a. 6-8 hrs

b. 24 hrs

c. 48 hrs

13.What will do the patient before get Electro convulsive therapy?

a. Empty the bladder

b. Intake of food

c. Intake of water

14.What type of cloth the patient wear for Electro convulsive therapy?

a. Tight cloth

b. Loose cloth

c. Cotton cloth

15.What are all the things remove from the patient before Electro convulsive therapy?

a. Dentures

b. Cloths

c. Intra venous canola

16.How to maintain hair before Electro convulsive therapy?

a. Apply the oil

b. Ensure the scalp clean and dry

c. Apply the lotion

17.What should be avoid before Electro convulsive therapy?

a. Avoid food and fluids

b. Bathing

c. Empty the bladder

18. What will you assess the patient after Electro convulsive therapy?

a. Conscious level

b. Physical ability

c. Visual acuity

19. What will immediately do after Electro convulsive therapy?

a. Provide food

b. Provide fluids

c. Re-oriented to patient

20. When will the patient become conscious after the Electro convulsive therapy?

a. 30-35 min

b. 40-45 min

c. 10-15 min

21. When the patient has excessive secretions, which kind of position can be maintained?

a. Supine position

b. Lateral position

c. Prone position

22.What kind of activities can be avoided after electro convulsive therapy?

a. Driving

b. Bed rest

c. Sleep

23.How many hours you need to accompanied with the client after the Electro convulsive therapy?

a. For 6 hrs

b. For 12 hrs

c. For 24 hrs

24.Which condition the patient needs intensive care after the Electro convulsive therapy?

a. Fever, shortness of the breath

b. Cold

c. Diarrhea

TOOL-III

ATTITUDE QUESTIONS

ATTITUDE QUESTIONNAIRE	**STRONGLY DISAGREE 1**	**DIS AGREE 2**	**UNCERTAIN 3**	**AGREE 4**	**STRONGLY AGREE 5**
1.Electro convulsive therapy is a painful procedure.					
2.Electro convulsive therapy is not effective treatment for mentally ill.					
3.Electro convulsive therapy is often given to people who do not need it.					
4.Treatment with Electro convulsive therapy is out dated.					
5.Treatment with Electro convulsive therapy is outlawed.					
6.Electro convulsive therapy is better treatment than					

medications.					
7.Electro convulsive therapy can reduce the severity of mental illness.					
8.Electro convulsive therapy is needed repeat once start.					
9.Electro convulsive therapy is the only choice of treatment for certain mental disorders.					
10.Electro convulsive therapy is the punishment for mentally ill patient.					
11.Memory loss may caused by electro convulsive therapy is not reversible.					
12.Electro convulsive therapy with medicine will be the effective treatment for mental disorders.					

13.Electro convulsive therapy may not cure all the mental illness.					
14.Electro convulsive therapy may cause severe pain to the patient.					
15.Electro convulsive therapy is dangerous treatment for mental illness.					

ANSWER KEY

TOOL-2 KNOWLEDGE OF CARE GIVERS REGARDING ELECTRO CONVULSIVE THERAPY

QUESTIONS NO	SCORE 1 (OPTION)
1	a
2	b
3	c
4	c
5	b
6	c
7	a
8	c
9	a
10	a
11	b
12	a
13	a
14	b
15	a
16	b
17	a
18	a
19	c
20	c
21	b
22	a
23	c
24	a

பொதுவான விவரம்

1.வயது வரம்பு

1. <25 வயதினர்
2. 26 - 35 வயதினர்
3. 36 - 45 வயதினர்
4. 46 - 55 வயதினர்
5. >56 வயதினர்

2. பாலினம்

1. பெண்
2. ஆண்

3.உறவுமுறை

1. கணவர் / மனைவி
2. பெற்றோர்கள்
3. மற்றவர்கள்

4.கல்வி தகுதி.

1. படிக்கவில்லை
2. தொடக்ககல்வி
3. இடை நிலை
4. மேல்லைப்பள்ளி
5. பட்டயபடிப்பு
6. பட்டபடிப்பு

5. பணிநிலை

1. வேலையுல்லவர்
2. வேலையில்லாதவர்

6. இருப்பிடம்

1. நகரம்
2. கிராமம்
3. பாதி நகரம்

7.நோயாளியோடு தங்கியிருந்த காலம் .

1. < 5 வருடம்
2. 6 - 10 வருடம்
3. >11 வருடம்

8. . முந்தைய தகவல் வழிகள்

1. சுகாதார அலுவலர்கள்
2. விளம்பர ஊடகங்கள்
3. நண்பர்கள் மற்றும் உறவினர்கள்
4. எதுவுமில்லை

அறிவுசார் கேள்விகள்

.மின் வலிப்போடு சிகிச்சை முறை பற்றிய கேள்விகள்

1.மின் வலிப்போடு சிகிச்சை என்றால் என்ன

1. மின் தூண்டுதல் வைத்தல்
2. மன மாற்று சிகிச்சை
3. மருந்து சிகிச்சை

2. .மின் வலிப்போடு சிகிச்சை யாரால் அளிக்கப்படும்

1. செவிலியர்
2. மனனலமருத்துவர்
3. மருத்தவ உளவியலார்

3. மின் வலிப்போடு சிகிச்சை ஒரு வாரத்திற்கு எத்தனை முறை அளிக்கப்படும்

1. ஐந்து முறை
2. ஒரு முறை
3. மூன்று முறை

4. மின் வலிப்போடு சிகிச்சை சராசரியாக ஒருநோயாளிக்கு எத்தனை முறை அளிக்கப்படும்

1. 1 -6 முறை
2. 6-12 முறை
3. 12-18 முறை

5. மின் வலிப்போடு சிகிச்சை எதன் மூலம் அளிக்கப்படும்

1. ஊசி
2. மாத்திரை
3. மின் வலிப்போடு இயந்திரம்

6. மின் வலிப்போடு சிகிச்சையின் பயன்பாடு என்ன

1. சிறுநீரக மாற்றத்தை சரிப்படுத்துதல்
2. இதய மாற்றத்தை சரிப்படுத்துதல்
3. மூளை மாற்றத்தை சரிப்படுத்துதல்

7. மின் வலிப்போடு சிகிச்சை யாருக்கெல்லாம் அளிக்கலாம்

1. மனஅழுத்தம்
2. இதய நோயாளி
3. வயதானவர்கள்

8. மின் வலிப்போடு சிகிச்சை யாருக்கெல்லாம் அளிக்ககூடாது

1. சிறுநீரக நோயாளி
2. இதய நோயாளி
3. வயதானவர்கள்

9. மின் வலிப்போடு சிகிச்சையின் பக்கவிளைவு என்ன

1. தற்காலிக மறதி
2. வயிற்றுபோக்கு
3. மாரடைப்பு

10. மின் வலிப்போடு சிகிச்சை அளிப்பதற்கு முன் எந்த முக்கியமான பரிசோதனை எடுக்க வேண்டும்

1. இரத்த குளுக்கோஸ் மற்றும் இ.சி.ஜி
2. ஹீமோக்ளோபின் மற்றும் சிறுநீரக பரிசோதனை
3. சி.டி ஸ்கேன் மற்றும் எம். ஆர்.ஐ

11. மின் வலிப்போடு சிகிச்சை அளிக்கும் சரியான நேரம் என்ன

1. இரவு
2. மாலை
3. காலை

12. . மின் வலிப்போடு சிகிச்சைக்கு முன் நோயாளி எவ்வளவு நேரம் உணவு மற்றும் நீர் அருந்தாமல் இருக்கவேண்டும்

1. 2-4 மணி நேரம்
2. 4-6 மணி நேரம்
3. 6-8 மணி நேரம்

13.மின் வலிப்போடு சிகிச்சை அளிப்பதற்கு முன் நோயாளி என்ன செய்ய வேண்டும்

1. சிறுநீர் கழிக்க வேண்டும்
2. உணவு உண்ணுதல்
3. நீர் அருந்துதல்

14. மின் வலிப்போடு சிகிச்சைக்கு எந்த மாதிரியான உடையை அணியவேண்டும்

1. இறுகிய உடை
2. மிகவும் இறுகிய உடை
3. தளர்ந்த உடை

15. மின் வலிப்போடு சிகிச்சைக்கு முன் நோயாளியிடமிருந்து எந்த பொருளை அகற்றவேண்டும்

1. நகைகள்
2. ஆடைகள்
3. நரம்புவழிக்குளாய்

16. மின் வலிப்போடு சிகிச்சைக்கு முன் தலையை எவ்வாறு பராமரிக்கவேண்டும்

1. தலைக்கு எண்ணெய் தேய்த்தல்
2. தலைக்குளித்து தூயிமையாக வைத்திருத்தல்
3. தலைக்கு லோசன் தடவுதல்

17. மின் வலிப்போடு சிகிச்சைக்கு முன்.எதை தவிர்த்தல் வேண்டும்

1. வாய்வழி ஆகாரம்
2. குளித்தல்
3. சிறுநீர்கழித்தல்

18.மின் வலிப்போடு சிகிச்சைக்கு.பிறகு நோயாளியிடமிருந்து எதை பரிசோதனை செய்ய வேண்டும்

1. சுய நினைவு
2. கண் பார்வை
3. கை,கால் அசை

19. மின் வலிப்போடு சிகிச்சைக்கு பிறகு நோயாளிக்கு உடனே என்ன செய்ய வேண்டும்

1. உணவு கொடுத்தல்
2. நீர் ஆகாரம் கொடுத்தல்
3. சுயநினைவுக்கு

20. மின் வலிப்போடு சிகிச்சைக்கு பிறகு சராசரியாக எவ்வளவு நேரத்தில் நோயாளி சுயநினைவுக்கு வருவார்

1. 10 - 15 நிமிடம்
2. 20 - 25 நிமிடம்
3. 30 - 35 நிமிடம்

21.மின் வலிப்போடு சிகிச்சைக்கு பிறகு நோயாளிக்கு வாயிலிருந்து அதிகமான அள எச்சில் சுரந்தால் நீங்கள்அவரை எவ்வாறு படுக்க வைப்பீர்கள்

1. குப்புற படுத்தல்
2. நேராக படுத்தல்
3. ஒரு பக்கமாக சாய்ந்து படுத்தல்

22.மின் வலிப்போடு சிகிச்சைக்கு பிறகு நோயாளி எந்த மாதிரியான வேலையை தவிர்த்தல் வேண்டும்

1. வாகனம் ஓட்டுதல்
2. ஓய்வு எடுத்தல்
3. தூங்குதல்

23.மின் வலிப்போடு சிகிச்சைக்கு பிறகு நீங்கள் எவ்வளவு நேரம் கூட இருக்கவேண்டும்

1. 6 மணி நேரம்
2. 12 மணி நேரம்
3. 24 மணி நேரம்

24.மின் வலிப்போடு சிகிச்சைக்கு பிறகு எந்த சூழ்நிலையில் நோயாளிக்கு அவசர சிகிச்சை தேவை

1. மூச்சுத்திணறல்
2. சளி பிடித்தல்
3. வயிற்று போக்கு

லைகேட் அளவுகோல் கொண்டு வலிப்போடு சிகிச்சை பற்றிய உறவினர்களின் எண்ணங்களை அறிதல்.

கீழ்கண்ட கேள்விகளுக்கு தகுந்த பதில்களை கவனமாக கேட்டு அல்லது படித்து பதில் அளிக்கவும்.

வ. எண்	விவரங்கள்	வலுவாகஒப்புக் கொள்ளவில்லை 1	ஒப்புக் கொள்ளவில்லை 2	தெளிவில்லை 3	ஒப்பு கொள்கிறேன் 4	வலுவாக ஒப்புகொள்கிறேன் 5
1.	மின் வலிப்போடு சிகிச்சை என்பது ஒரு பயம் மிகுந்த சிகிச்சை					
2.	மின் வலிப்போடு சிகிச்சை என்பது மனநோயாளிகளுக்கான சரியான சிகிச்சை முறை அல்ல					
3.	மின் வலிப்போடு சிகிச்சை முறை தேவையில்லாத மனநோயாளிகளுக்கும் கொடுக்கப்படுகிறது					
4.	மின் வலிப்போடு சிகிச்சை முறை என்பது ஒரு					

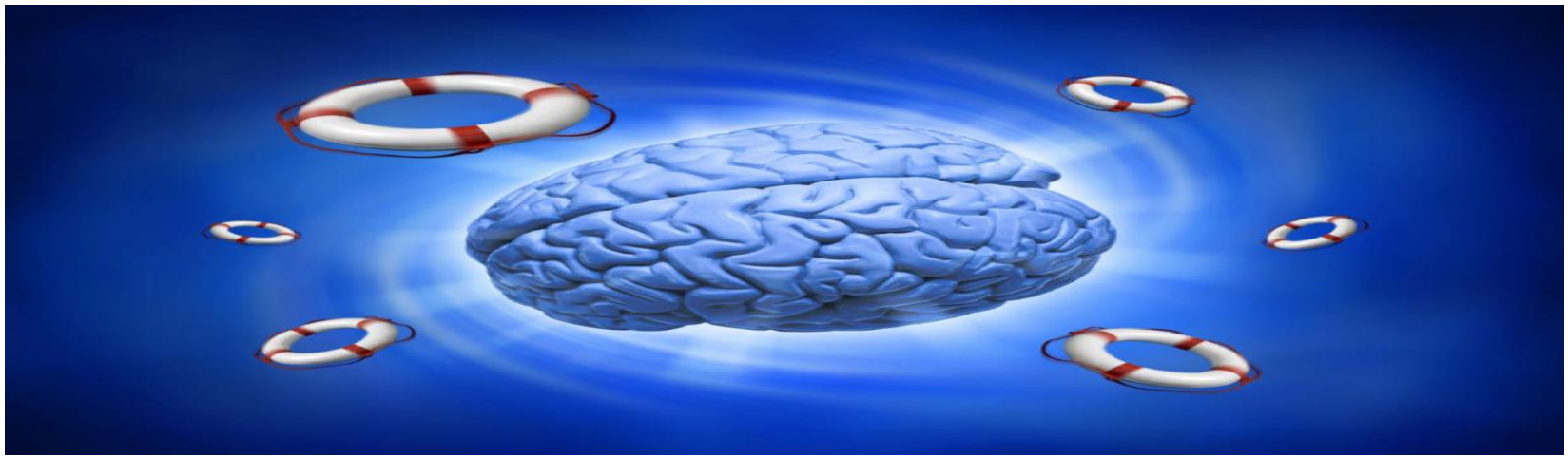
	காலவதியான சிகிச்சை முறை					
5.	மின் வலிப்போடு சிகிச்சை சட்ட விதிக்குட்பட்டது					
6.	மின் வலிப்போடு சிகிச்சை முறை மருந்து மாத்திரையை விட சிறந்தது					
7.	மின் வலிப்போடு சிகிச்சை மனநோயின் வீரியத்தை குறைக்கும்					
8.	மின் வலிப்போடு சிகிச்சை ஒரு முறை எடுத்தால் திரும்பத்திரும்ப அதே சிகிச்சையை தான் எடுக்கவேண்டும்					
9.	சில மனநோய்க்கு மின் வலிப்போடு சிகிச்சை தான் சரியான சிகிச்சை முறை					
10.	மின் வலிப்போடு					

	சிகிச்சை மனநோயளிக்கான தண்டனை முறை ஆகும்					
11.	மின் வலிப்போடு சிகிச்சை எடுப்பதால் உருவாகும் மறதி திரும்ப நினைவுக்கு வராது					
12.	மின் வலிப்போடு சிகிச்சையோடு மருந்து மாத்திரையும் சேர்த்து சிகிச்சை அளிப்பதே சிறந்தது					
13.	மின் வலிப்போடு சிகிச்சை எல்லா மனநோயையும் குணப்படுத்தாது					
14.	மின் வலிப்போடு சிகிச்சை மனநோயாளிக்கு வலியை ஏற்படுத்தும்					
15.	மின் வலிப்போடு சிகிச்சை மனநோய்க்கான ஆபத்தான சிகிச்சை முறையாகும் .					

PSYCHOEDUCATION

ON

ELECTRO CONVULSIVE THERAPY



GENERAL OBJECTIVES:

The care givers will able to understand and gain knowledge and develop their skills regarding safe handling of ECT patients and have a positive attitude of the ECT treatment.

SPECIFIC OBJECTIVES:

The care givers will be able to,

- define ECT
- describe the administration of ECT
- enlist the indications and contra-indications of ECT
- explain the functions of ECT
- enumerate the side effects of ECT
- explain about preparation for ECT
- brief about after administration of ECT
- explain about outpatient discharge advice
- discrete the risk associated with ECT

LESSON PLAN

Name of the subject: Mental Health and Psychiatric Nursing

Name of the Topic: Electro convulsive therapy

Venue: Athma and Sowmanasya psychiatric hospitals

Duration: 1 hour

Group: Care givers of mentally ill patients

Method of teaching: Lecture cum discussion

AV Aids used: LCD, Flashcards

Name of the Researcher : Mrs.Durgadevi.P, II year M.Sc(N), OLHCON,Thanjavur.

Name of the Research guide: Mrs.Vanitha Innocent Rani MSc (N), PhD

TIME	SPECIFIC OBJECTIVES	CONTENTS	A.V AIDS	RESEARCHER'S ACTIVITY	LEARNER'S ACTIVITY	EVALUATION
1 min		**Good morning to all,** Today, ECT remains one of the most controversial treatments for psychological disorders and continuous to be the subject of impassioned debate among various factors of society, with in both professional and lay communities. So,we are definitely know about the ECT treatment for the purpose of remove the misconceptions about the benefits and risk of the ECT treatment. **Definition:** The induction of grandmal (generalized)Seizure through the application of electrical current to the brain.				
2min	Define the ECT	The stimulus is applied through electrodes that are placed either bilaterally in	LCD	Lecture cum discussion	Listening	What is mean by ECT?

		the front temporal region or unilaterally on the same side as the dominant hand. Greater efficacy in some clients for less confusion and acute amnesia with unilateral placement. Treatments are performed on an inpatient basis for those who require close observation and care. Those at less risk may have the option of receiving therapy at an outpatient treatment facility. **ECT TEAM:** • Psychiatrist • Nurse • Nursing aid **TREAMENT FACILITY:**				
8min	Describe the ECT team and treatment facilities		Flash cards	Lecture cum discussion	Listening	What are all the treatment facilities for ECT?

		a)Pre ECT Room: Comfortable waiting room with adequate seating facilities both for client and attainders. **b)ECT Room:** Well equipped with sophisticated machinery facilities like: ➢ ECT Machine ➢ Anesthetic appliance ➢ Suction apparatus ➢ Accessibility to defibrillator accessories ➢ Oxygen cylinder with adjustable valve ➢ Curved tongue depressor ➢ Mouth gag ➢ Resuscitation apparatus ➢ Emergency drugs **c)Post recovery room:** ➢ 6-8 beds ➢ Suction apparatus ➢ Ventilator assistance ➢ Emergency drugs				

5min	Describe the administration of ECT	**HOW IS IT ADMINISTERED:** ECT treatment is generally administered in the morning, before breakfast. Prior to the actual treatment, the is given general anesthesia and a muscle relaxant. The electrodes are then attached to the patient's scalp and an electric current is applied which causes a brief convulsion. The duration of the seizure should be at least 15-25 seconds.  Minutes later the patients awakens confused and without memory of events surrounding the treatment. Most clients awaken with in 10 or 15 minutes of the treatment. Some clients will sleep for 1 to 2 hours following the treatment.	LCD	explaining	Listening	What medications are used to during the ECT?

		This treatment is usually repeated 3 times a week for approximately one month. The number of treatments varies from 6 to 12. **WHY IS ECT SO CONTROVERSIAL?** After 60 years of use, ECT is still the most controversial psychiatric treatment. Much of the controversy surrounding ECT revolves around its effectiveness vs the side effects, the objectivity of ECT as a quick and easy solution, instead of long-term psychotherapy or hospitalization. **INDICATIONS:** ➢ Major depression ➢ Acute manic episodes of bipolar disorder ➢ Acute schizophrenia, particularly if it is accompanied by catatonic or affective symptomatology. ➢ Obsessive compulsion disorders				

10min	Enlist the indications and contraindications for ECT	➢ Personality disorder **CONTRA-INDICATIONS:** ✓ Absolute contraindication for ECT is, increased intracranial pressure from brain tumor, recent cardiovascular accident or other cerebrovascular lesion. ✓ Myocardial infarction or CVA with in the preceding 3-6 months, ✓ Aortic or cerebral aneurysm, severe underlying hypertension and congestive heart failure. ✓ Other factors clients at risk from ECT include severe osteoporosis, acute and chronic pulmonary disorders and high-risk or complicated pregnancy.	Flash cards	Lecture cum discussion	Listening	What is the contra indications for ECT?

3 min	Explain the functions of ECT	**HOW IT IS FUNCTION?** Electrical stimulation results in significant increases in the circulating levels of several transmitters. ECT can help the growth of new cells and nerve pathways in certain areas of the brain.	LCD	Explaining	Listening	How does the ECT works?
4 min	Enumerate the side effects of ECT	**SIDE EFFECTS OF ECT:** **Short term:** o Headache and some aching in their muscles. o They may feel muzzy headed and generally out of sorts, or bit sick. o Temporary loss of memory o Contraction of the jaw muscles o Chance of damage to the tongue, teeth and lips o Confusion **Long term:**	LCD	Lecture cum discussion	Listening	What is the common side effects for ECT?

5 min	Explain about preparation for ECT	○ Memory has been permanently affected that their memories never come back **PREPARATION FOR ECT:** ❖ In the days before you start a course of ECT, your doctor will arrange for you to have some tests to make sure it is safe for you to have a general anesthetic. These may include: - Chest x-ray - A tracing of your heart working (ECG) - Blood tests ❖ Complete physical examination particularly thorough assessment of cardiovascular and pulmonary status. ❖ The nurse may be responsible for ensuring that informed consent has been obtained from the client. If the depression is severe and the client is clearly unable to consent to the	Flash cards	explaining	Listening	How long the patient maintain NPO for before ECT?

		procedure, permission may obtained from family or another legally responsible individual. Informed consent may require for safety of the both patient and ECT team members. ❖ You will be asked not to have anything to eat or drink for 6-8 hours before the ECT. This is so that the anesthetic can be given safely. ❖ Approximately 1 hour before treatment is scheduled, take vital signs and record them. Have the client void and remove dentures, eye classes or contact lenses, jewelry and hairpins.   ❖ Approximately 30 minutes before treatment, administer the				

15min	Brief about after the administration of ECT	pretreatment medication as prescribed by the physician. **AFTER THE ECT ADMINISTRATION:** ▪ Check the vital signs for every 15 minutes for the first 1 hour.  ▪ Position the client on side to prevent the aspiration.  ▪ Provide the reassurance that confusion and memory loss will subside and memories should return following the course of ECT treatment.	LCD	Explaining	Listening	When the patient awaken for after the ECT?

3 min	Explain about outpatient discharge advice.	▪ Allow the client verbalize fears and anxieties related to receiving ECT. ▪ Stay with the client until he or she fully awake, oriented, and able to perform self care activities without assistance. **OUT PATIENT DISCHARGE ADVICE:** You must : • Be in the company of responsible adult for 24 hours following the treatment. • Be accompanied home. • Not leave the hospital if you are feeling unsteady or confused. • Not operate machinery or appliances for 24 hours. • Take DVLA advice on driving following of mental illness. (your psychiatrist should inform you of this) • Not be left in sole charge of young children until the following morning. • Not sign any legal document or make	LCD	Explaining	Listening	What are all the things following after discharge?

2min	Discrete the risk associated with ECT	important decisions for 24 hours. • Not consume alcohol for 24 hours • Once you have return to home if you begin to feel unwell contact the Doctor. Like severe headache, back and neck pain . • If the patient have epilepsy, fever, breathing difficulty means immediately patient send to the emergency department. **RISK ASSOCIATED WITH ECT THERAPY:** • MORTALITY Mortality rate from ECT is about 2 per 100,000 treatments. Although occurrence is rare, the major course of death with ECT is from cardiovascular complications. • Permanent memory loss • Brain damage	LCD	Explaining	Listening Listening	What are all the risk factors for ECT?

SUMMARY:

So far we have discussed about ECT, definition, administration of ECT, indication, contra-indications, functions of ECT, side effects and how to prepare the client for ECT can improve their knowledge and attitude regarding ECT.

CONCLUSION:

Through this class, the care givers are refresh their knowledge about ECT and improved the skills when they handling the client , with ECT , at the same time their attitude also developed.

காலம்	குறிக்கோள்	பொருளடக்கம்	கற்பிப்பவர் செயல்பாடுகள்	கற்றறிபவர் செயல்பாடுகள்	ஒலி ஒளித் துணைக்கலங்கள்	மதிப்பீடு
1 நிமிடம்	பாடத்தை அறிமுகப்படுத்துதல்	**முன்னுரை:** ❖ மின்வலிப்போடு சிகிச்சை என்பது மூளைக்கு மின்சாரத்தை செலுத்துவதன் மூலம் வலிப்பை தூண்டும் முறை ஆகும்.	அறிமுகப்படுத்துதல்	கவனித்தல்		
2 நிமிடம்	**மின்வலிப்போடு சிகிச்சை அளிக்கும்முறைகள் வரையறை** செய்தல்	**மின்வலிப்போடு சிகிச்சை அளிக்கும்முறைகள்** ◉ எலேக்ட்ரோடுகள் நோயாளியின் இடது மற்றும் வலது நெற்றியில் வைத்து மின்சாரம் செலுத்தப்படும். ◉ அல்லது எதாவது ஒருபக்கம் நெற்றியில் ஒரு எலக்ட்ரோடும் அதே பக்கத்தில் தலையில் ஒரு எலக்ட்ரோடும் வைத்து மின்சாரத்தை செலுத்தி வலிப்பை தூண்டுதல்	விவாதித்தல்	கவனித்தல்	திரவபடிகக் காட்சி	**மின்வலிப்போடு சிகிச்சை அளிக்கும் முறைகள்** என்றால் என்ன?

8 நிமிடம்	**மின்வலிப் போடு சிகிச்சைக் கான வசதிகள்** வரையறுத் தல்	வேண்டும் . ◉ இந்த இரு பக்க மின்வலிப்போடு சிகிச்சை அளிப்பதன் மூலம், நோயாளிக்கு குறைவான குழப்பமும் மற்றும் வீரியம் குறைந்த மறதி நோயும் தான் உருவாகும் இதனால் ஒருபக்க சிகிச்சையை விட இருபக்க சிகிச்சையே சிறந்தது . தற்போது இரு பக்க மின்வலிப்போடு சிகிச்சை நோயாளிக்கு அளிக்கப்படுகிறது. **மின்வலிப்போடு சிகிச்சையின் குழு உறுப்பினர்கள் :** ◉ **மன நல மருத்துவர்** ◉ **செவிலியர்** ◉ **செவிலிய உதவியாளர்** **மின்வலிப்போடு சிகிச்சைக்கான வசதிகள்** ◉ **அளிப்பதற்கு முன் காத்திருக்கும் அறை;**	விவாதித்தல்	சந்தேகங்களை கேட்டறிதல்	துண்டுபிரசுரம்	

		◉ மின்வலிப்போடு சிகிச்சை அளிக்கும் இயந்திரம், ◉ மயக்கமருந்து அளிப்பதற்கு தேவையான கருவிகள் ◉ எச்சில் உறிஞ்சும் கருவி, ◉ முதலுதவி கொடுக்கும் இயந்திரம், ◉ ஆக்ஸிஜன் ◉ மருந்து மாத்திரைகள் .   ◉ பிறகு நோயாளி இருக்கும் அறை:				

		◉ 6 - 8 கட்டில்கள், ◉ எச்சில் உறிஞ்சும் கருவி, மருந்து மாத்திரைகள் **மின்வலிப்போடு சிகிச்சைஎவ்வாறு அளிக்கப்படும் ;** ◉ பொதுவாக காலை நேரத்தில் காலை உணவு எடுப்பதற்கு முன் அளிக்கப்படும். ◉ அளிப்பதற்கு முன் மயக்கமருந்தும், தசை தளர்த்தி மருந்தும் அளிக்கப்படும் . வலிப்பு சராசரியாக 15-25 வினாடி வரை இருக்கும் . பின் கொஞ்சம் நேரம் கழித்து நோயாளி சிறிது குழப்பதுடனும், தற்காலிக மறதியுடனும் இருப்பார் ◉ பொதுவாக பல நோயாளிகள் 10லிருந்து 15 நிமிடத்தில் விழித்துக் கொள்வார் .சிலர் 1-2 மணி				

5 நிமிடம்	**மின்வலிப் போடு சிகிச்சைஅ ளிக்கப்படு ம் நோயாளிக** ளை பற்றி விவாதித்த ல்.	நேரம் வரை தூங்குவர். ◉ பொதுவாக ஒரு வாரத்திற்கு 3 முறை அளிக்கப்படும். மொத்த சிகிச்சையின் எண்ணிக்கை ஒரு நோயளிக்கு 6-12 சிகிச்சை அளிக்கப்படும் . ◉ **மின்வலிப்போடு சிகிச்சைஅளிக்கப்படும் நோயாளிகள்: மன அழுத்தம் (depression)**  ◉ **இருமுனை கோளாறு (bipolar disorder)** ◉ மனச்சிதைவு கோளாறு (schizophrenia)	விவாதித்தல்	கற்றறிபவரிடம் கலந்துரையாடல் மற்றும் விவாதித்தல்	திரவபடிகக் காட்சி	

10 நிமிடம்	**மின்வலிப் போடு சிகிச்சையி**	◉ ஆளுமை கோளாறு (personality disorder) ◉ திரும்ப திரும்ப ஒரு வேலையை செய்யும் நோய் (obsessive compulsive disorder) **மின்வலிப்போடு சிகிச்சை எந்த நோயாளிகளுக்கு அளிக்ககூடாது:** ◉ மூளைக்கட்டி ◉ பக்கவாதம் மற்றும் மாரடைப்பு வந்து 3-6 மாதங்கள் வரை மின்வலிப்போடு சிகிச்சைகொடுக்கக்கூடாது ◉ உயர் இரத்த அழுத்தம் ◉ இதய செயல்பாடுமின்மை ◉ நுரையீரல் நோய், ◉ மூட்டு தேய்மானம் , ◉ சிக்கல் நிறைந்த கர்ப்பிணி பெண்களுக்கு தவிர்த்தல் . ◉ **மின்வலிப்போடு சிகிச்சையின் செயல்பாடு ;**	கற்றறிபவரிடம் கலந்துரையாடல் மற்றும்			

	ன் செயல்பாடுளை கணக்கிலெடுத்தல்	**மின் தூண்டுதலின் மூலமாக நரம்புகடத்திகளின் செயல்பாடுஅதிகமாகும் . இதனால் மூளையில் புதிய செல்களும், நரம்பணு பாதையும் சிறப்பாக அமையும் .**	விவாதித்தல்			
3 நிமிடம்	**மின்வலிப்போடு சிகிச்சையின் பக்க விளைவுக**ளை கணக்கிலெடுத்தல்	**மின்வலிப்போடு சிகிச்சையின் பக்க விளைவுகள்** ◉ தலைவலி மற்றும் தசை வலி ◉ தலைபாரம் தற்காலிக மறதி ◉ மனக்குழப்பம் நாக்கு பல் மற்றும் உதடுகள் உருக்குலைதல் ◉ தாவங்க்கொட்டை தசைகள் இறுக்கமாதல்	கற்றறிபவரிடம் கலந்துரையாடல் மற்றும் விவாதித்தல்			
15 நிமிடம்	**மின்வலிப்போடு சிகிச்சைஅ**	**மின்வலிப்போடு சிகிச்சைஅளிப்பதற்கு முன் பின்பற்ற வேண்டியவை ;**				

	ளிப்பதற்கு முன் பின்பற்ற வேண்ட ளை கணக்கிலெடுத்தல்	◉ மருத்துவர் நோயாளிக்கு மின்வலிப்போடுசிகிச்சை அளிப்பதற்கு முன் சில பரிசோதனை செய்வார் . ◉ அவற்றுள் குறிப்பாக , ◉ மார்பாக எக்ஸ்ரே, ◉ இ.சி.ஜி, ◉ இரத்த பரிசோதனை ◉ முழு உடல் பரிசோதனை முக்கியமாக இதய மற்றும் நுரையீரல் பரிசோதனை செய்ய வேண்டும். ◉ செவிலியர் மின்வலிப்போடு சிகிச்சைஅளிப்பதற்கு முன் ஒப்புதல் தகவல் படிவத்தில் நோயாளியிடமிருந்து கையெழுத்து வாங்க வேண்டும் . ◉ நோயாளி ரொம்ப முடியாமல் இருந்தால் சட்டப்படி அவருடைய				

		குடும்ப உறவினர் அல்லது அவரோடு யார் தங்கி இருக்கிறாரோ அவரிடம் வாங்க வேண்டும் . இது நோயாளி மற்றும் குழு உறுப்பினர்களின் பாதுகாப்பிற்காக வாங்கப்படுகிறது ◉ மின்வலிப்போடு சிகிச்சை அளிப்பதற்கு முன் நோயாளி 6-8 மணி நேரம் வரை வாய்வழி ஆகாரம் எடுக்கக் கூடாது (உணவு மற்றும் நீர்). இது மயக்கமருந்து பாதுகாப்பாக கொடுக்க பின்பற்றப்படுகிறது . மின்வலிப்போடு சிகிச்சை அளிப்பதற்கு முன் சராசரியாக 1 மணி நேரத்திற்கு முன்பாகவே நாடித்துடிப்பு , ரத்த அழுத்தம் , உடல் வெப்பநிலையை கணக்கிட				

15 நிமிடம்	**மின்வலிப் போடு**	வேண்டும் . ◉ மின்வலிப்போடு சிகிச்சைஅளிப்பதற்கு முன் சிறுநீர் கழிக்க செய்தல், ◉ மின்வலிப்போடு சிகிச்சைஅளிப்பதற்கு முன் நோயாளியிடமிருந்து போலிப்பற்கல் , நகைகள் , கண் கண்ணாடி,காண்டக்ட் லென்ஸ் மற்றும் உலோக பொருளை அகற்ற வேண்டும் மின்வலிப்போடு சிகிச்சைஅளிப்பதற்கு அரை மணி நேரத்திற்கு முன்பாக மயக்க மருந்து மற்றும் தசை தளர்த்தி மருந்தை நோயாளிக்கு அளிக்க வேண்டும் **மின்வலிப்போடு சிகிச்சைஅளித்ததற்கு பின் பின்பற்ற வேண்டியவை ;**				

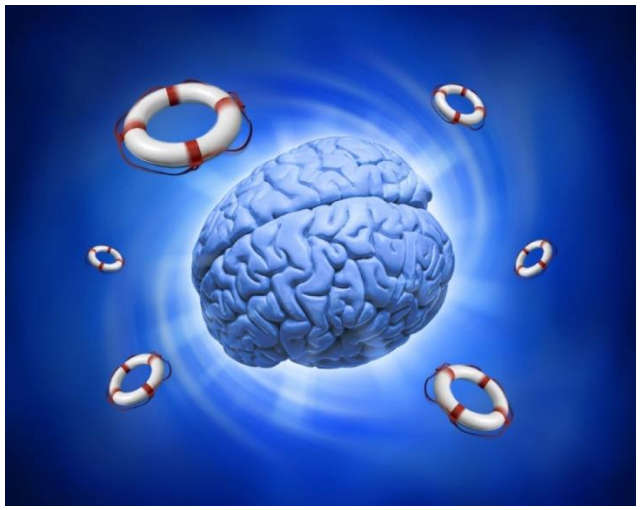
	சிகிச்சைஅ ளித்ததற்கு பின் பின்பற்ற வேண்டிய வைகளை பதிவுசெய்த ல்	◉ செவிலியர் 15 நிமிடத்திற்கு ஒரு முறை நாடித்துடிப்பு , ரத்த அழுத்தம் உடல் வெப்பநிலையை இவற்றை முதல் 1 மணி நேரத்திற்கு பார்க்க வேண்டும். ◉ புரையேருதலை தடுக்க நோயாளியை ஒரு பக்கமாக படுக்க வைக்க வேண்டும் . ◉ பின் நோயாளியை குழப்பத்தில் இருந்து வெளிக்குணரவும், மறதியை போக்கி அவரை நோக்குநிலைப் படுத்த வேண்டும். ◉ நோயாளியின் பயம் மற்றும் கவலையை வெளிப்படுத்துவதர்க்கான அனுமதியை அளிக்க வேண்டும்				

5 நிமிடம்	**வெளி நோயாளி வீட்டுக்கு செல்லும் போது மருத்துவர் கொடுக்கும் ஆலோசனைகளை** பதிவுசெய்தல்	**வெளி நோயாளி வீட்டுக்கு செல்லும் போது மருத்துவர் கொடுக்கும் ஆலோசனை;** **முதல் 24 மணி நேரம் நோயாளியுடன் இருக்க வேண்டும்.** ◉ **நோயாளி குழப்பதுடனும், நடக்க முடியாமலும் இருந்தால் அவரை மருத்துவமனையிலிருந்து வீட்டிற்கு அழைத்து செல்லக்கூடாது** ◉ **முதல் 24 மணி நேரத்திற்கு நோயாளி எந்த இயந்திரதையும் இயக்கக் கூடாது .** ◉ **முதல் 24 மணி நேரத்திற்கு நோயாளி ஆல்கஹால் அருந்தக்கூடாது.** ◉ **முதல் 24 மணி நேரத்திற்கு நோயாளி**				

		எந்தஒரு முக்கியமான சட்ட அறிக்கையிலும் கையெழுத்து மற்றும் முடிவு எடுக்க கூடாது ◉ நோயாளியோட பாதுகாப்பிற்காக குழந்தைகளை விட்டு செல்லக் கூடாது. ◉ நோயாளிக்கு அதிகமான தலைவலி , உடல் வலி இருந்தால் மருத்துவரை அணுகவும். ◉ முதல் 24 மணி நேரத்திற்கு நோயாளி வாகனம் ஓட்டுதல் கூடாது. நோயாளிக்கு மூச்சு விடுதலில் கடினமாகவும், காய்ச்சல், வலிப்பு இருந்தால் நோயாளியை உடனடியாக அவசர சிகிச்சைக்கு கொண்டு செல்லவும். ◉ **மின்வலிப்போடு**				

3 நிமிடம்	**மின்வலிப் போடு சிகிச்சையின் காரணமாக ஏற்படும் விளைவுகள**	**சிகிச்சையின் காரணமாக ஏற்படும் விளைவுகள:** ◉ இறத்தல்; 100,000 எடுக்கும் பேரில் 2 பேர் இறக்கிறார்கள் ,இது எப்பயாவதுதான் நடக்கும் அதற்கு காரணம் நோயாளி இதய நோயால் பாதிபட்டவராக இருந்தால் நடக்கும். ◉ நிரந்தரமான மறதி ஏற்படும் ◉ மூளை உருக்குலைதல்				

மின்வலிப்போடு சிகிச்சை பற்றிய



அறிவுறைகள்